NEVADA STATE BOARD

of

DENTAL EXAMINERS

LEGAL & DISCISPLINARY ACTION COMMITTEE MEETING

JUNE 28, 2012

6:15 p.m.

PUBLIC COPY

TITLE 54 - PROFESSIONS, OCCUPATIONS AND BUSINESSES

CHAPTER 622 - GENERAL PROVISIONS GOVERNING REGULATORY BODIES

GENERAL PROVISIONS

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GENERAL PROVISIONS

NRS 622.005 Definitions. As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 622.020 to 622.060, inclusive, have the meanings ascribed to them in those sections.
(Added to NRS by 2003, 1185, 3416)

NRS 622.020 "Immediate relative" defined. "Immediate relative" means:
1. A spouse.
2. A parent, by blood, marriage or adoption.
3. A child, by blood, marriage or adoption.
(Added to NRS by 2003, 1185)

NRS 622.030 "License" defined. "License" means any license, certificate, registration, permit or similar type of authorization issued by a regulatory body.
(Added to NRS by 2003, 1185, 3416)

NRS 622.040 "Licensee" defined. "Licensee" means a person who holds any license, certificate, registration, permit or similar type of authorization issued by a regulatory body.
(Added to NRS by 2003, 1185, 3416)

NRS 622.050 "Member of a regulatory body" defined. "Member of a regulatory body" means a person who is serving as a member or officer of a regulatory body.
(Added to NRS by 2003, 1185)

NRS 622.060 "Regulatory body" defined. "Regulatory body" means:
1. Any state agency, board or commission which has the authority to regulate an occupation or profession pursuant to this title; and
2. Any officer of a state agency, board or commission which has the authority to regulate an occupation or profession pursuant to this title.
(Added to NRS by 2003, 1185, 3416; A 2005, 752)

REGULATORY DUTIES

NRS 622.080 Duty to enforce provisions of title for protection and benefit of public. In regulating an occupation or profession pursuant to this title, each regulatory body shall carry out and enforce the provisions of this title for the protection and benefit of the public.
(Added to NRS by 2003, 1185, 3417)

NRS 622.090 Duty to apply grading methodology included in examination to determine passage of examination. Notwithstanding the provisions of any specific statute to the contrary, if a regulatory body, in any testing authorized or required pursuant to this title or any regulations adopted pursuant thereto, uses or accepts a national or other examination which is produced or administered by an organization other than the regulatory body and which includes a methodology for determining the level of performance that constitutes a passing grade or score on the examination, the regulatory body shall apply that methodology in determining whether a person who took the examination achieved a passing grade or score.
(Added to NRS by 2007, 2939)

REPORTS

NRS 622.100 Quarterly reports of disciplinary actions and regulatory activities; duties of Director of Legislative Counsel Bureau.
1. Each regulatory body shall, on or before the 20th day of January, April, July and October, submit to the Director of the Legislative Counsel Bureau in an electronic format prescribed by the Director:

(a) A summary of each disciplinary action taken by the regulatory body during the immediately preceding calendar quarter against any licensee of the regulatory body; and
(b) A report that includes:
(1) The number of licenses issued by the regulatory body during the immediately preceding calendar quarter; and
(2) Any other information that is requested by the Director or which the regulatory body determines would be helpful to the Legislature in evaluating whether the continued existence of the regulatory body is necessary.
2. The Director shall:
(a) Provide any information received pursuant to subsection 1 to a member of the public upon request;
(b) Cause a notice of the availability of such information to be posted on the public website of the Nevada Legislature on the Internet; and
(c) Transmit a compilation of the information received pursuant to subsection 1 to the Legislative Commission quarterly, unless otherwise directed by the Commission.
3. The Director, on or before the first day of each regular session of the Legislature and at such other times as directed, shall compile the reports received pursuant to paragraph (b) of subsection 1 and distribute copies of the compilation to the Senate Standing Committee on Commerce and Labor and the Assembly Standing Committee on Commerce and Labor, each of which shall review the compilation to determine whether the continued existence of each regulatory body is necessary.
(Added to NRS by 2001, 947; A 2003, 1186, 3418; 2007, 2939; 2009, 2940, 2941)

ADMINISTRATION AND PERSONNEL

NRS 622.200 Training of members; Attorney General authorized to charge for training.
1. As soon as practicable after a person is first appointed to serve as a member of a regulatory body, the person must be provided with:
(a) A written summary of the duties and responsibilities of a member of the regulatory body; and
(b) Training on those duties and responsibilities by the Attorney General. The training must include, without limitation, instruction related to the audit that is required by NRS 218G.400, except that a person who is a member of the Nevada State Board of Accountancy is not required to be provided with instruction related to that audit.
2. The Attorney General may, in accordance with the provisions of NRS 228.113, charge a regulatory body for all training provided pursuant to paragraph (b) of subsection 1.
(Added to NRS by 2003, 1185; A 2011, 368)

NRS 622.205 Conditions and limitations regarding members who are not licensees of regulatory body. A member of a regulatory body who is not a licensee of the regulatory body of which he or she is a member:
1. Shall reside in this State;
2. Must be a person of recognized ability and integrity;
3. Shall not have substantial personal or financial interests in the practice of any occupation or profession that the regulatory body has the authority to regulate or in any organization regulated by that regulatory body;
4. Shall not have an immediate relative who has substantial personal or financial interests in the practice of any occupation or profession that the regulatory body has the authority to regulate or in any organization regulated by that regulatory body;
5. Shall not be an officer, board member or employee of a statewide or national organization established for the purpose of advocating the interests of or conducting peer review of licensees of the regulatory body on which he or she serves; and
6. Must not be a registered lobbyist representing any interest or association relating to the practice of any occupation or profession that the regulatory body has the authority to regulate.
(Added to NRS by 2009, 871)

NRS 622.210 Conditions and limitations regarding employment of person whose immediate relative is licensee of regulatory body. Except as otherwise provided in NRS 622.220, a regulatory body may not employ a person whose immediate relative is a licensee of the regulatory body, unless the regulatory body implements policies and procedures to prevent the person who is employed by the regulatory body from participating in any activities that are directly related to the licensee.
(Added to NRS by 2003, 1186)

NRS 622.220 Conditions and limitations regarding employment of person as executive director or executive secretary or in similar position. If a regulatory body employs a person as an executive director or executive secretary or in a position with powers and duties similar to those of an executive director or executive secretary, the person:
1. Must possess a level of education or experience, or a combination of both, to qualify the person to perform the administrative and managerial tasks required of the position; and
2. Must not be the immediate relative of:
(a) A member or employee of the regulatory body; or
(b) A licensee of the regulatory body.
(Added to NRS by 2003, 1186)

NRS 622.230 Conditions and limitations regarding contracting with person to provide services as independent contractor. A regulatory body may not contract with a person to provide services to the regulatory body as an independent contractor if the person is the immediate relative of:
1. A member or employee of the regulatory body; or
2. A licensee of the regulatory body, unless the regulatory body implements policies and procedures to prevent the person who is the independent contractor from participating in any activities that are directly related to the licensee.
(Added to NRS by 2003, 1186)

REGULATORY PROCEEDINGS; RECORDS

NRS 622.300 Duty of licensee to disclose certain information regarding immediate relatives. If a licensee of a regulatory body appears before the regulatory body concerning any matter that is within the jurisdiction of the regulatory body, the licensee must disclose, to the best of his or her knowledge, whether an immediate relative of the licensee:
1. Is employed by the regulatory body; or
2. Has any financial, business, professional or personal relationship with a member or employee of the regulatory body.
(Added to NRS by 2003, 1186)

NRS 622.310 Certain medical information and records protected from disclosure. If any provision of this title requires a regulatory body to disclose information to the public in any proceeding or as part of any record, such a provision does not apply to any personal medical information or records of a patient that are confidential or otherwise protected from disclosure by any other provision of federal or state law.
(Added to NRS by 2003, 3417)

NRS 622.315 Sharing of information relating to public health concerns; joint investigations with Health Division of Department of Health and Human Services.
1. Any regulatory body may share information in its possession relating to public health concerns with any other regulatory body and with the Health Division of the Department of Health and Human Services, if the confidentiality of the information is otherwise maintained in accordance with the terms and conditions required by law.
2. Any regulatory body may conduct a joint investigation with the Health Division if either of them so requests and the regulatory body and the Health Division agree that each of them will benefit from conducting a joint investigation.
(Added to NRS by 2009, 870)

NRS 622.320 Inapplicability of certain provision of Open Meeting Law to certain investigatory proceedings; applicability of that provision to certain disciplinary proceedings.
1. The provisions of NRS 241.020 do not apply to proceedings relating to an investigation conducted to determine whether to proceed with disciplinary action against a licensee, unless the licensee requests that the proceedings be conducted pursuant to those provisions.
2. If the regulatory body decides to proceed with disciplinary action against the licensee, all proceedings that are conducted after that decision and are related to that disciplinary action are subject to the provisions of NRS 241.020.
(Added to NRS by 2003, 3417)

NRS 622.330 Consent and settlement agreements: Procedure for approving; deemed public records; exceptions.

1. Except as otherwise provided in this section, a regulatory body may not enter into a consent or settlement agreement with a person who has allegedly committed a violation of any provision of this title which the regulatory body has the authority to enforce, any regulation adopted pursuant thereto or any order of the regulatory body, unless the regulatory body discusses and approves the terms of the agreement in a public meeting.

2. A regulatory body that consists of one natural person may enter into a consent or settlement agreement without complying with the provisions of subsection 1 if:

(a) The regulatory body posts notice in accordance with the requirements for notice for a meeting held pursuant to chapter 241 of NRS and the notice states that:

(1) The regulatory body intends to resolve the alleged violation by entering into a consent or settlement agreement with the person who allegedly committed the violation; and

(2) For the limited time set forth in the notice, any person may request that the regulatory body conduct a public meeting to discuss the terms of the consent or settlement agreement by submitting a written request for such a meeting to the regulatory body within the time prescribed in the notice; and

(b) At the expiration of the time prescribed in the notice, the regulatory body has not received any requests for a public meeting regarding the consent or settlement agreement.

3. If a regulatory body enters into a consent or settlement agreement that is subject to the provisions of this section, the agreement is a public record.

4. The provisions of this section do not apply to a consent or settlement agreement between a regulatory body and a licensee that provides for the licensee to enter a diversionary program for the treatment of alcohol, chemical or substance abuse or dependency.

(Added to NRS by 2003, 3417)

NRS 622.340 Requirements for meetings conducted by audio or video teleconference.

1. Except as otherwise provided in NRS 622.330, notice of a meeting of a regulatory body, as required pursuant to NRS 241.020, must indicate whether the meeting will be conducted by an audio or video teleconference at one or more locations.

2. If a regulatory body conducts a meeting by an audio or video teleconference at a location specified in the notice pursuant to subsection 1, the regulatory body shall allow any person present at that location to participate in the meeting.

3. The provisions of this section do not prohibit a regulatory body from holding a closed meeting or preventing a person from participating in a meeting in accordance with chapter 241 of NRS.

(Added to NRS by 2005, 2698)

NRS 622.350 Certain meetings conducted outside State prohibited.

1. A regulatory body shall not hold a meeting at a location that is outside this State if:

(a) The meeting is subject to the provisions of chapter 241 of NRS; and

(b) During the meeting or any portion of the meeting, the regulatory body conducts any business relating to this title.

2. The provisions of subsection 1 do not prohibit a member of a regulatory body from attending an educational seminar, retreat for professional development or similar activity that is conducted outside this State.

(Added to NRS by 2005, 2697)

NRS 622.360 Disciplinary proceedings: Licensee required to submit fingerprints; additional grounds for disciplinary action.

1. If a regulatory body initiates disciplinary proceedings against a licensee pursuant to this title, the licensee shall, within 30 days after the licensee receives notification of the initiation of the disciplinary proceedings, submit to the regulatory body a complete set of his or her fingerprints and written permission authorizing the regulatory body to forward the fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report.

2. The willful failure of the licensee to comply with the requirements of subsection 1 constitutes an additional ground for the regulatory body to take disciplinary action against the licensee, including, without limitation, suspending or revoking the license of the licensee.

3. A regulatory body has an additional ground for taking disciplinary action against the licensee if:

(a) The report from the Federal Bureau of Investigation indicates that the licensee has been convicted of an unlawful act that is a ground for taking disciplinary action against the licensee pursuant to this title; and

(b) The regulatory body has not taken any prior disciplinary action against the licensee based on that unlawful act.

4. To the extent possible, the provisions of this section are intended to supplement other statutory provisions governing disciplinary proceedings. If there is a conflict between such other provisions and the provisions of this section, the other provisions control to the extent that the other provisions provide more specific requirements regarding the discipline of a licensee.

(Added to NRS by 2005, 2698)

ATTORNEY'S FEES AND COSTS

NRS 622.400 Recovery of attorney's fees and costs incurred by regulatory body in certain regulatory proceedings.

1. A regulatory body may recover from a person reasonable attorney's fees and costs that are incurred by the regulatory body as part of its investigative, administrative and disciplinary proceedings against the person if the regulatory body:

(a) Enters a final order in which it finds that the person has violated any provision of this title which the regulatory body has the authority to enforce, any regulation adopted pursuant thereto or any order of the regulatory body; or

(b) Enters into a consent or settlement agreement in which the regulatory body finds or the person admits or does not contest that the person has violated any provision of this title which the regulatory body has the authority to enforce, any regulation adopted pursuant thereto or any order of the regulatory body.

2. As used in this section, "costs" means:

(a) Costs of an investigation.

(b) Costs for photocopies, facsimiles, long distance telephone calls and postage and delivery.

(c) Fees for court reporters at any depositions or hearings.

(d) Fees for expert witnesses and other witnesses at any depositions or hearings.

(e) Fees for necessary interpreters at any depositions or hearings.

(f) Fees for service and delivery of process and subpoenas.

(g) Expenses for research, including, without limitation, reasonable and necessary expenses for computerized services for legal research.

(Added to NRS by 2003, 3417)

NRS 622.410 Recovery of attorney's fees and costs incurred by regulatory body in certain judicial actions. A court shall award to a regulatory body reasonable attorney's fees and reasonable costs specified in NRS 18.005 that are incurred by the regulatory body to bring or defend in any action if:

1. The action relates to the imposition or recovery of an administrative or civil remedy or penalty, the enforcement of any subpoena issued by the regulatory body or the enforcement of any provision of this title which the regulatory body has the authority to enforce, any regulation adopted pursuant thereto or any order of the regulatory body; and

2. The court determines that the regulatory body is the prevailing party in the action.

(Added to NRS by 2003, 3418)

Investigation and Processing of Disciplinary "Complaints"

John A. Hunt, Esq., Board Legal Counsel

Since January 1990, I have acted as General Counsel &Prosecutor for the Board. Since then the disciplinary process has changed to meet the needs of the citizens of the State of Nevada. The following is an outline of how disciplinary actions are currently investigated and processed.

The disciplinary process usually begins with a telephone communication and/or a letter of complaint from the complainant. These complaints are first handled by the Board's executive director. The Board's executive director then assigns those complaints to a disciplinary screening officers.

Upon review of the complaints by the respective disciplinary screening officers, herein referred to as the DSO, the DSO determines whether to request the complainant file a verified compliant. Sometimes a complaint filed by the complainant is verified from its inception.

NRS 631.360(1) states:

> "1. The board may, upon its own motion, and shall, upon verified complaint in writing of any person setting forth facts which, if proven, would constitute grounds for refusal, suspension or revocation of a license or certificate under this chapter, investigate the actions of any person holding a certificate."

Unless a complaint has been verified, the DSO may only contact the complainant and the licensee. Upon verification of the Complaint the DSO may contact third parties (i.e. witnesses, experts, subpoena records) to determine whether there have been any violations of either NRS 631 or NAC 631. It should be noted pursuant to NRS 631.360(1), the Board may, on its own motion, authorize an investigation. Such investigations usually result from anonymous information which the Board, by motion, must authorize an investigation. Once the complaint is verified it is forwarded to the licensee for response. Pursuant to NAC 631.240(2), a licensee must file a response within fifteen (15) days after he receives notice and a copy of the complaint. Upon review of the complaint, the answer, and conducting a preliminary investigation, the DSO has three (3) options.

1. The DSO may remand the matter to the file. In such cases the complainant and licensee are usually informed that although the DSO has remanded the matter to the file, in the event there are any future complaints, the remanded matters may be reviewed in any future disciplinary actions. It should be noted, the remand can be done with or without conditions. Pursuant to NRS 631.368, letters of remand are not public record nor are they reportable to the National Practitioners Data Bank.

2. The DSO may enter into a stipulation with the licensee. Usually, stipulations are entered into wherein the licensee has had prior letters of remand, therefore warranting additional remedial action. Stipulations are submitted to the Board for approval. The stipulations are public record and the actions taken, pursuant to the stipulation, may or may not be reportable to the National Practitioners Data Bank. The benefit of a stipulation versus proceeding to an informal hearing, as described below, is with a stipulation there is no transcript regarding the testimony given by the licensee during the course of an informal hearing. In the event the DSO finds there has been a violation of any provision of the Dental Practice Act, by entering into a stipulation, any further costs, which are usually assessed to the licensee, are minimized.

3. The DSO may request an Informal Hearing Officer be assigned to the matter. According to current Board policy, the DSO handling the initial review is assigned as the Informal Hearing Officer. The assignment of an Informal Hearing Officer is authorized pursuant to NRS 631.363(1) which states:

> "1. The board may appoint one of its members and any of its employees, investigators or other agents to conduct an investigation and informal hearing concerning any practice by a person constituting a violation of the provisions of this chapter or the regulations of the board."

After further investigation, the Informal Hearing Officer has two (2) options.

1. The DSO again may remand the matter to the file with or without conditions. The remand usually will inform the licensee and the complainant that although no further action shall be taken by the Board, in the event any future complaints are lodged, the remanded action may be reviewed in determining future disciplinary action.

2. The DSO/Informal Hearing Officer may request the licensee appear for an informal hearing. Pursuant to NRS 631.363, the licensee shall be given at least ten (10) days' notice before the setting of an informal hearing. The informal hearing pursuant to NAC 631.255, must be transcribed in permanent form by a court reporter licensed to do business in Nevada. A licensee may choose to appear with or without counsel. The Informal Hearing Officer, Board Counsel, licensee, counsel for the licensee, and the court reporter are usually the only individuals present at the informal hearing. Whether or not the licensee chooses to appear at the informal hearing, the Findings and Recommendations are prepared by the DSO/Informal Hearing Officer and submitted to the Board for consideration. Thereafter, the Board may set the matter for a full Board hearing to consider whether or not to implement the Findings and Recommendations submitted by the DSO/Informal Hearing Officer. At the full Board hearing the complainant, licensee, witnesses and experts may give testimony for both sides.

At the conclusion of the informal hearing the Informal Hearing Officer has three (3) options.

1. To remand the matter to the file as previously described above.

2. Remand the matter to the file with a finding there were no violations of either NRS 631 or NAC 631.

3. Pursuant to NRS 631.363(3), the Informal Hearing Officer may issue findings regarding violations in either

NRS 631 and/or NAC 631. Upon the finding of a violation of either NRS 631 or NAC 631, the Informal Hearing Officer then makes recommendations as to the appropriate discipline for the identified violations. The Findings and Recommendations are reduced to writing.

In the event the Informal Hearing Officer issues written Findings & Recommendations pursuant to NRS 631.363(5), the licensee who is investigated may consent to the Findings & Recommendations of the Informal Hearing Officer.

If the licensee chooses not to consent to the findings and recommendation the prosecutor for the Board may file a formal complaint with the Board based upon those Findings and Recommendations requesting a full Board Hearing.

If the licensee consents to the Findings & Recommendations the Board, at its option, may adopt the Findings & Recommendations as its final order without conducting a full Board hearing on the matter.

If the Board either refuses to adopt the consented Findings & Recommendations or, if the licensee chooses not to consent to the Findings & Recommendations, a formal complaint may be filed by the prosecutor requesting a full Board hearing. In the event there is a full Board hearing pursuant to NRS 631.363(4), the Informal Hearing Officer shall not participate in the full Board hearing. However, the Board may consider the Findings & Recommendations of the Informal Hearing Officer. A copy of the Findings & Recommendations must be sent to the licensee being investigated pursuant to NRS 631.363(3). At the conclusion of the full Board hearing the Board may impose discipline, if any, pursuant to NRS 631.350. The disciplinary options available to the Board run the gamut from public reprimand to revocation.

Once a final decision is rendered by the Board pursuant to NRS 233B.130 a licensee may petition the District Court for judicial review. The petition for judicial review must be filed within thirty (30) days after service of final decision of the Board. A licensee may also request a rehearing within fifteen (15) days of the date after service of the final decision. Pursuant to NRS 233B.130(4), an order granting or denying the petition for rehearing must be served at least five (5) days before expiration of the time for the filing of a petition for judicial review.

Judicial review, pursuant to NRS 233B.135, of a final decision of the Board

must be conducted by a Court without a jury and confined to the record. The District Court shall not substitute its judgment for that of the agency as to the weight of evidence on a question of fact. The District Court may remand or affirm a final decision of the Board or, set it aside in whole or in part if substantial rights of the licensee have been prejudiced because of a final decision of the Board.

The burden of proof is upon the licensee to prove the Board's final decision was based on one of the following grounds:

a. In violation of constitution or statutory provisions;

b. In excess of the statutory authority of the Board;

c. Made upon unlawful procedure;

d. Affected by other error of law;

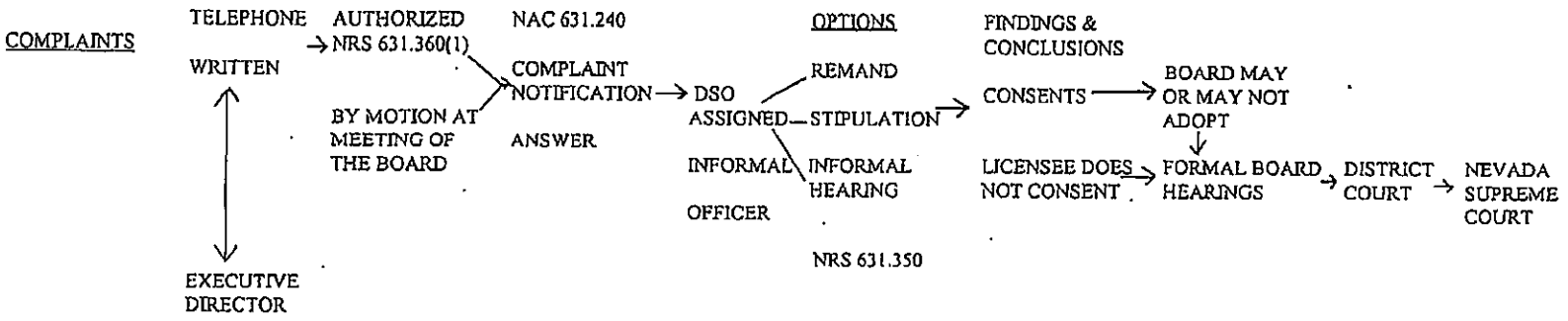
e. Clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or

f. Arbitrary, capricious, or characterized by abuse of discretion.

Finally, the Board or the licensee subsequent to the District Court's ruling may appeal the decision to the Nevada Supreme Court.

The information contained above is a summary of the disciplinary process and administrative procedures currently implemented by the Nevada State Board of Dental Examiners pursuant to NRS 631, NAC 631, NRS 233B, and NAC 233B. The summary given above should not be considered to be all inclusive. The reader should review the statutes and regulations cited above for a more in-depth understanding of the procedures and regulations that control the investigative and disciplinary process regarding dentists in the State of Nevada. Licensees should contact independent counsel should they have specific questions regarding the legal significance of the procedures cited above.

INVESTIGATIONS



PROPOSED MOTION BY DR. PICK

Motion: Pursuant to NRS 631.363 (1), I hereby move that the Board's policies regarding the assignment of Disciplinary Screening/Informal Hearing Officers be revised as follows:

1. The present Disciplinary Screening/Informal Hearing Officers are hereby reaffirmed to execute those duties. Currently the Disciplinary Screening Officers/Informal Hearing Officers authorized by the Board are Dr. Robert Lysgaard, Dr. Stephen C. Vaughn, Dr. Susan S. Jancar, Dr. Dennis J. Arch, and Dr. William J. Busch.

2. Pursuant to this motion, the Disciplinary Screening/Informal Hearing Officers already approved shall continue with the matters presently assigned.

3. The number of Disciplinary Screening Officers/Informal Hearing Officers shall not be limited to any given number. The Board shall appoint dentists to act as Disciplinary Screening/Informal Hearing Officers upon those dentists being approved by the Board at a properly noticed meeting. A Disciplinary Screening Officer and/or Informal Hearing Officer may be appointed to matters within their same geographical area.

4. Once a dentist has been appointed by the Board as a Disciplinary Screening/Informal Hearing Officer, the Board's Executive Director shall have the authority and may assign Disciplinary Screening/Informal Hearing Officers to new matters being processed by the Board's Executive Director. In the event a Disciplinary Screening Officer and/or Informal Hearing Officer, for any reason, can no longer process a given matter, the Board's Executive Director shall have the authority to appoint a substitute Disciplinary Screening Officer and/or Informal Hearing Officer.

5. Once a dentist has been approved by the Board and assigned to a matter by the Board's Executive Director, the Disciplinary Screening/Informal Hearing Officers will conduct reviews and/or investigations pursuant to the following procedures:

   a. Upon the Executive Director's receiving an oral complaint, either in person or by telephone conversation, if the matter cannot be resolved by the Executive Director, the Executive Director may assign the matter, to a Disciplinary Screening Officer who in turn may contact only the complainant and the licensee in an attempt to resolve the complaint. In the event the Disciplinary Screening Officer assigned believes further review is necessary, the Disciplinary Screening Officer will request the Executive Director attempt to have the oral complaint verified in order to commence an investigation pursuant to NRS 631.360 and NRS 631.363.

   b. Upon the Executive Director receiving a non-verified written complaint and the non-verified complaint cannot be resolved by the Executive Director, the Executive Director may assign the non-verified written complaint to a Disciplinary Screening Officer. In the event the Disciplinary Screening Officer assigned determines no further action is necessary, the Disciplinary Screening Officer may remand the matter to the Board's files.

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Adopted 3/30/98 Minutes

In the event the Disciplinary Screening Officer assigned believes further review is necessary, the Disciplinary Screening Officer will request the Executive Director attempt to have the non-verified written complaint verified in order to commence an investigation pursuant to NRS 631.360 and NRS 631.363.

c. If the Executive Director receives a verified complaint, pursuant to NRS 631.360, the Executive Director shall forward the verified complaint to the licensee for an answer. Upon receiving the answer of the licensee, the Executive Director shall assign a Disciplinary Screening Officer and forward copies of both the complaint, answer, and any supplemental information to the assigned Disciplinary Screening Officer. If the assigned Disciplinary Screening Officer, after investigating the complaint and the answer and reviewing same with Board counsel, determines no further action is necessary, the complaint, answer, and any supplemental information, the matter may be remanded to the Board's files. If the Disciplinary Screening Officer determines a further investigation is necessary, the Disciplinary Screening Officer assigned shall automatically become the Informal Hearing Officer assigned to the matter. Thereafter, the Disciplinary Screening/Informal Hearing Officer is authorized to conduct an informal hearing as set forth in NRS 631.363.

Nevada State Board of Dental Examiners
Telephone Conference
March 30, 1998

President Twesme called the meeting to order at 5:30 pm.

1. **Roll Call and Establish a Quorum**

President Twesme asked VaLonne Harmon, Executive Director, to call the roll.

Dennis Arch, DDS	PRESENT
Judy Bowmer, RDH	PRESENT
Larry L. Champagne, DMD	PRESENT
Tony Guillen, DDS	PRESENT
Joyce Herceg, RDH	PRESENT
Michael G. Hollingshead, DDS	PRESENT
Samuel E. Pick, DDS	PRESENT
Mrs. Dorothy Raggio	EXCUSED
Bradley Roberts, DDS	PRESENT
A. Ted Twesme, DDS	PRESENT

Also present was John A. Hunt, Esq., Board Counsel, and VaLonne Harmon. Guests were Betty Pate, RDH; Mary Bobbitt, RDH; Leanne Truesdale, DDS; Ms. Armida Jones; Ms. Dominique Jones; Ms. Donna Carpenter; and Cassius Battle. With a quorum present, the meeting was opened for business at 5:33 pm.

2. **Old Business**

a. Dr. Twesme led a discussion of the proposals submitted by lobbyists who are interested representing the Board during the 1999 legislative session. On motion by Dr. Champagne, seconded by Dr. Pick, the Board voted unanimously to invite all eight (8) lobbyists to a regular board meeting. Ms. Harmon was authorized and directed to contact each of the firms to schedule interviews at the Friday, April 24, 1998, meeting in Las Vegas.

b. The next item of business was a discussion of the proposal regarding the hiring of a legislative liaison to work with the Board president and the lobbyist. Dr. Twesme reiterated Dr. Jancar's offer to serve in this position.

After discussion, on motion by Ms. Bowmer, seconded by Dr. Champagne, the Board voted unanimously to assign the duties of the legislative liaison to current Board members. By this vote, the Board also authorized reimbursement of Dr. Jancar's expenses for the Mid-year AADE meeting in Chicago. Further, because the contract was not adopted, any future expenditures must be pre-approved by the Board.

c. The Board discussed the dates for the 1999 dental and dental hygiene licensure examination. On motion by Dr. Roberts, seconded by Dr. Arch, action on this matter was tabled for consideration at the April 24, 1998, meeting.

3. **New Business**

a. Mr. Hunt reviewed suggested revisions to the protocol for processing complaints and the Disciplinary Screening Panel. Mr. Hunt stated that the complaint process was progressing very smoothly and that the revisions were necessary to make minor adjustments to previously adopted protocol. Dr. Pick read the following motion into the record, it was seconded by Dr. Hollingshead, and the Board voted unanimously to adopt the motion as read.

Motion: Pursuant to NRS 631.363 (1), I hereby move that the Board's policies regarding the assignment of Disciplinary Screening/Informal Hearing Officers be revised as follows:

1. The present Disciplinary Screening/Informal Hearing Officers are hereby reaffirmed to execute those duties. Current the Disciplinary Screening/Informal Hearing Officers authorized by the Board are Dr. Robert Lysgaard, Dr. Stephen C. Vaughn, Dr. Susan S. Jancar, Dr. Dennis J. Arch, and Dr. William J. Busch.

2. Pursuant to this motion, the Disciplinary Screening Officers/Informal Hearing Officers already approved shall continue with the matters presently assigned.

3. The number of Disciplinary Screening Officers/Informal Hearing Officers shall not be limited to any given number. The Board shall appoint dentists to act as Disciplinary Screening Officers/Informal Hearing Officers upon those dentists being approved by the Board at a properly noticed meeting. A Disciplinary Screening Officer/Informal Hearing Officer may be appointed to matters within their same geographical area.

4. Once a dentist has been appointed by the Board as a Disciplinary Screening Officer/ Informal Hearing Officer, the Board's Executive Director shall have the authority and may assign Disciplinary Screening Officers/Informal Hearing Officers to new matters being processed by the Board's Executive Director. In the event a Disciplinary Screening Officer and/or Informal Hearing Officer, for any reason, can no longer process a given matter, the Board's Executive Director shall have the authority to appoint a substitute Disciplinary Screening Officer and/or Informal Hearing Officer.

5. Once a dentist has been approved by the Board and assigned to a matter by the Board's Executive Director, the Disciplinary Screening Officers/Informal Hearing Officers will conduct reviews and/or investigations pursuant to the following procedures:

a. Upon the Executive Director's receiving an oral complaint, either in person or by telephone conversation, if the matter cannot be resolved by the Executive Director, the Executive Director may assign the matter to a Disciplinary Screening Officer who, in turn, may

contact only the complainant and the licensee in an attempt to resolve the complaint. In the event the Disciplinary Screening Officer assigned believes further review is necessary, the Disciplinary Screening Officer will request the Executive Director attempt to have the oral complaint verified in order to commence an investigation pursuant to NRS 631.360 and NRS 631.363.

b. Upon the Executive Director receiving a non-verified written complaint and the non-verified complaint cannot be resolved by the Executive Director, the Executive Director may assign the non-verified written complaint to a Disciplinary Screening Officer. In the event the Disciplinary Screening Officer assigned determines no further action is necessary, the Disciplinary Screening Officer may remand the matter to the Board's files. In the event the Disciplinary Screening Officer assigned believes further review is necessary, the Disciplinary Screening Officer will request the Executive Director attempt to have the non-verified written complaint verified in order to commence an investigation pursuant to NRS 631.360 and NRS 631.363.

c. If the Executive Director receives a verified complaint pursuant to NRS 631. 360, the Executive Director shall forward the verified complaint to the licensee for an answer. Upon receiving the answer of the licensee, the Executive Director shall assign a Disciplinary Screening Officer and forward copies of both the complaint, answer, and any supplemental information to the assigned Disciplinary Screening Officer. If the assigned Disciplinary Screening Officer, after investigating the complaint and the answer and reviewing same with Board counsel, determines no further action is necessary, the complaint, answer, and any supplemental information may be remanded to the Board's files. If the Disciplinary Screening Officer determines a further investigation is necessary, the Disciplinary Screening Officer assigned shall automatically become the Informal Hearing Officer assigned to the matter. Thereafter, the Disciplinary Screening Officer/Informal Hearing Officer is authorized to conduct an informal hearing as set forth in NRS 631.363.

3. <u>New Business (continued)</u>

b. The next item of business to come before the Board was the consideration of Dr. Bradley Roberts for the position of Disciplinary Screening Officer/Informal Hearing Officer. On motion by Dr. Arch, seconded by Dr. Pick, the Board voted unanimously to name Dr. Roberts as a Disciplinary Screening Officer/Informal Hearing Officer. Dr. Roberts abstained from voting.

c. There then came on before the Board a request by the Executive Director to authorize investigations into the actions of two license dentists. On motion by Dr. Pick, seconded by Dr. Champagne, the Board voted unanimously to authorize an investigation of Dr. X based on action by another jurisdiction and an investigation of Dr. Y for failure to report an incident pursuant to NRS 631.155.

d. The next item of business to come before the Board was a request from the Nevada Dental Association that the Board participate in NDA's state-wide newsletter. After discussion, the Board

authorized and directed Mr. Hunt to draft an article regarding the statutes and regulations along with common violations and provide this information to the NDA newsletter editorial staff.

e. There then came on before the Board requests from two dentists for certification in specialty areas of dentistry. After reviewing the applications and credentials, the Board took the following action: On motion by Dr. Guillen, seconded by Mrs. Herceg, the Board voted unanimously to grant specialty certification for the practice of Endodontics to Margaret M. Ashe, DDS. On motion by Dr. Roberts, seconded by Dr. Arch, the Board voted unanimously to grant specialty certification for practice in the field of Pediatric Dentistry to Dawn L. McClellan, DDS.

Dr. Twesme announced that Ms. Armida Jones, a member of the public, was present to address the Board regarding dental anesthesia. On motion by Dr. Pick, seconded by Mrs. Bowmer, the Board voted unanimously to go off the agenda and allow Ms. Jones to speak. Ms. Jones related that on August 18, 1992, her son, Cassius Battle, was sedated for dental treatment by an anesthesiologist working with a pediatric dentist. As a result of equipment malfunction, Cassius had significant brain damage during the treatment. Ms. Jones encouraged the Board to adopt stringent regulations regarding dental anesthesia. Ms. Jones answered questions from Board counsel, and Dr. Twesme thanked her for her interest in this matter. The Board assured Ms. Jones that the regulations were undergoing review and revision with the goal of protecting patients.

f. The Board considered the next agenda item, requests for conscious sedation permits. After review and discussion of the applications, on motion by Dr. Guillen, seconded by Dr. Arch, the Board voted unanimously to approve the applications and thereby grant temporary permits to Dawn L. McClellan, DDS, and William F. Waggoner, DDS. The temporary permits are granted based on successful completion of site visits. Dr. Brooksby withdrew his application for a conscious sedation permit.

g. There then came on before the Board a consideration of the findings and stipulated agreement, in re: Sidney R. Adams, DDS. Mr. Hunt reviewed the stipulated agreement and informed the Board of their option with regard to adopting or rejecting the agreement. On motion by Dr. Arch, seconded by Dr. Roberts, the Board voted unanimously to adopt the stipulated agreement with Dr. Adams.

h. The next item of business to come before the Board was consideration of a stipulated agreement, in re: Kerry D. Hanson, DDS. Mr. Hunt reviewed the terms of the agreement along with the circumstances regarding Dr. Hanson's request to re-activate his Nevada dental license with certain limitations. On motion by Dr. Hollingshead, seconded by Dr. Guillen, the Board voted unanimously to adopt the stipulated agreement with Dr. Hanson.

4. Announcements

Mrs. Harmon reported on Mrs. Raggio's medical condition, and the Board discussed sending cards on an individual basis.

5. Adjournment

There being no further business to come before the Board at this time, on motion by Dr. Arch, seconded by Dr. Guillen, the Board voted unanimously to adjourn the meeting at 6:55 pm.

Respectfully submitted,

VaLonne Harmon

VaLonne S. Harmon, Executive Director

Index of documents

Exhibit #	Description
Exhibit 1	Discussion regarding history and use of corrective action stipulations since 2000. Also there is discussion about May 2011 letter from the Director of the Data Banks, Ms. Grubbs stating the Board was in compliance with the data banks' reporting requirements. See attached as **sub-exhibit 1-C**. The May 2011 letter from Ms. Grubb was sent AFTER a letter was sent on behalf of the Board dated March 3, 2011 (responding to a February 2011 letter from Ms. Grubbs), advising and discussing, in part, corrective action stipulations which were not reported to the data banks. Id. Again, Ms. Grubbs' May 2011 determination the Board was in compliance with the data banks' reporting requirements came AFTER she was advised of the Board's reasoning and basis for its use of corrective action stipulations and why they were not reported to the data banks. Id. AFTER reviewing this information, Ms. Grubbs' May 2011 letter advises the Board it was in compliance with data banks' reporting requirements. This determination by Ms. Grubbs that the Board is in compliance with its reporting to the data banks is confirmed by the data banks website which notes Nevada, Dentist, as being "Compliant" for its status as of 4/1/2011, 7/1/2011, 10/1/2011, and 12/1/2011 (the latest date referenced). Sub-exhibits within this **Exhibit 1:** **Exhibit A:** 8-29-11 description of duties for Board employees **Exhibit B:** Corrective action stipulation history from 2000. **Exhibit C:** copy of the following letters and their respective attachments: * Ms. Grubbs' February 2011 letter to the Board * 2-3-11 response letter on behalf of the Board to Ms. Grubbs' letter * **Ms. Grubbs' May 2011 letter to the Board advising the Board is in reporting compliance**
Exhibit 2	Data banks website page printout noting "Nevada" "Dentist" reporting being "compliant" for the periods there has been review from 4/1/11 to 12/1/11
Exhibit 3	Table and discussion/comment regarding latest version of certain sections of the Code of Federal Regulations (CFR) re: the National Practitioner Data Bank ("NPDB")
Exhibit 4	Table and discussion/comment regarding latest version of certain CFR sections re: Healthcare Integrity and Protection Data Bank ("HIPDB")
Exhibit 5	Discussion of material regarding "HIPDB Guidebook" noting example of non-reportable actions and discussion of material regarding power point presentation by Ms. Grubb
Exhibit 6	Discussion of "Dear Data Bank" from May 2012 Newsletter
Exhibit 7	Examples of other Boards using corrective action agreements/orders and NOT REPORTING them to the data banks

Exhibit 1

Exhibit 1

At the request of William Busch, DDS Executive Director for the Board a position was created and approved by the Board in October of 2002 at a properly noticed meeting to hire Ms. Shaffer and Ms. Shaffer hire date is October 21, 2002. Ms. Shaffer position is to handle the administration of complaints and disciplinary process. This is consistent with duties described in the August 29, 2011 document from Kathleen Kelly, Executive Director.
See Exhibit A

Attached as Exhibit B are examples of stipulation agreements from 2000 to current and a summary attached. The 2000 to current time frame is consistent with the NPDB Guidelines dated September 2001.

As you review the stipulation agreements you will see different Disciplinary Screening Officers, Board Presidents and Board Members. Although, the DSO's, Board Presidents and Board Members have changed over the years the reporting of corrective versus adverse actions has not changed. However, the amount of information contained in the stipulation agreements has increased to better protect the citizens of the State of Nevada.

On February 2, 2011, the Board received correspondence from the Division of Practitioners Data Banks "DPDB" regarding an audit for compliance of certain adverse actions taken by the Board that were not reported to the NPDB. On March 3, 2011, I responded to the "DPDB" with a response as well as exhibits including the NPDB Guidelines referencing Section E-24 and E-25. Eleven actions did not meet the NPDB Adverse Action Reporting Requirements for Licensing Boards. The additional five in question were updated and reported, one action was reported and I included the DCN reference number. See Exhibit C

On May 25, 2011, the Board received from the Health Resource and Service Administration (HRSA), Bureau of Health Professions, Division of the Practitioners Data Bank, a letter advising the Board of "compliance" status as it relates to the certain adverse actions in question during the period of 2006-2009. Eleven corrective actions were not and have not been reported as they are not required pursuant to the NPDB Guidelines. Five adverse actions were updated and have been reported. One was originally reported including the NPDB identifying number.

Further, in reviewing the NPDB Guidelines the terms "corrective action plans" and "adverse actions" are terms used throughout the NPDB Guidelines. To insure consistency with the NPDB and based on the correspondence dated May 25, 2011 from the Director of the Division of Practitioners Data Banks I began using these terms in the stipulation agreements to better identify those which are deemed as adverse and are reportable to the NPDB and those corrective action stipulations/settlements that are non-reportable to the NPDB based on their Guidelines.
See Exhibit C

As you review the stipulation agreements dating back from 2000 to current and the information from the NPDB you will see my position regarding "corrective" (non-reportable) and "adverse" (reportable) has not changed and is confirmed to be "compliant" as stated in the correspondence from Ms. Grubbs, Director of the Division of Practitioners Data Banks dated May 25, 2011.

EXHIBIT A

Nevada State Board of Dental Examiners

William G. Peppas, D.D.S.
President

Donna J. Hellwinkel, D.D.S.
Secretary-Treasurer

6010 S. Rainbow Blvd., Bldg. A, Ste. 1 • Las Vegas, NV 89118 • (702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

DUTIES: As of 8/29/2011

Kathleen J. Kelly: Executive Director 8am – 5pm (Additional hours as scheduled)

- Agency Chief
- Application Review
- Ensure Chapter Compliance (NRS/NAC)/Disciplinary matters
- Certify Board Documents/ Issue Subpoenas
- Budget/ Financial management
- Media Contact/Board Legal Counsel Coordination
- Legislative Management / Nevada Legislature
- Issuance of Suspensions/Revocations/Reinstatements
- Liaison with Licensing Software Vendor
- CE Stipulation Approvals and Stipulation Compliance (Monitor with Thiriot)
- CCOH Board Liaison
- Certify Minutes Preparation
- Public Document Requests/State Liaison
- Exam coordination

Debra A. Shaffer: Deputy Executive Director 8:00am – 5pm (Additional hours as scheduled)

- Assist Overall Agency Management (back-up ED)
- Process Complaints / Meet w/ Complainants (By appt: Wednesdays 1-5pm)
- Coordinate Complaint Notice to Licensees
- Process Disciplinary Cases
- Meet with Complainants
- Coordinate Disciplinary Investigators
- Report Disciplinary Cases / LCB
- Manage Stipulation Compliance (Monitor with Thiriot)
- Process Disciplinary Payments
- Process False Advertising Claims
- Manage Malpractice Filings
- Monitor Disciplinary Filings of Notice

Candice Stratton: Licensing Specialist 8:30am – 5:30pm

- Manage/Process Licensing: general; specialty; restricted; limited; hygiene; geo restricted
- Process Pocket Cards / Certificates
- Manage/Initiate License Renewal Process: Assisted by Rigo/Sandra/Angie
- Process Reinstatements for Inactive/Suspended/Revoked
- Process Local/N20 Applications/Approval
- Process Check Transactions: Detail/Summary

Rick Thiriot, DDS: DSO Coordinator (Wed 1-4) (Part-time)

- Coordinate/Train DSO / Hearing Officers

Compliance Monitor for Board Actions / Stipulation Agreements
Process Complaint Notices
Review Complaints / Meet with Complainants for Dental Review

Sandra Spilsbury Administrative Assistant II 8am – 5pm

Process Applications/Coordinate Clinical Licensure Examinations: Dental and Hygiene
Process Public Health Dental Hygiene Endorsements
Process Continuing Education Applications/Review Requirements/Audit
Scheduling
Process Travel: Staff and Members
Office Administration / Order Equipment/Furniture/Repairs
Jurisprudence Examination Coordination / Fingerprinting (back up for Rigo)
Update all Applications / Forms / Packets
Rulemaking/Meetings Postings
Newsletter
Anesthesia Administration (Conscious Sedation, Deep Sedation, General Anesthesia): Schedule Exams/permit processing/re-evals

Rigoberto Morales: Administrative Assistant II 7:30am – 4:30pm

Coordinate Jurisprudence Examination
Maintain and Process Fingerprinting Verification
Credit Card Processing/ Transaction/Payments Data Entry
Website Management
General Filing
Process Stipulation Agreement/ Board Action Requests
Verification of Licensure Requests
Process Address Changes/Updates/ Process Name Changes
Answer Phones/Process Mail (back up for Angie for phones)
Media Clippings
Assist Monitoring Stipulations with Thiriot

Angelica Bejar: Staff Assistant/Receptionist 8am – 5pm

Front Office Reception: Answer calls/Direct calls / Greet Visitors
Process Incoming Mail: including faxes
General Filing
Board Meetings: Coordinate Board Book Preparations
Maintain Minutes Book (Draft Minutes) and Board Agendas
Disseminate Email from NSBDE Master Account for Reply
Assist Deputy ED with processing complaint forms
Data Entry for Licensing System –Assist Candice
Prepare/Mail Friday Packets to all Board Members
General Administrative Duties

Andrew Kachurak: Board Investigator (Part Time) (Reno)

Background Investigations
Investigative Research/Surveillance
Interviews Witnesses/Collects Evidence
Assists DSO/HO with Complaint Investigations

EXHIBIT B

STIPULATION HISTORY (NSBDE) 2000-2011 -- Date of NPDB Guidelines September 2001

Joseph Eberle, DDS

Stipulation- reimburse Board cost of invest, monitored for 2 year, initiate informed consent forms
Approved 06/2000- DSO-Stephen Vaughn, DDS – President Dr Twesme – attorney Hunt (Not reportable to NPDB)

Lisa Hogan, DDS

Stipulation-practice monitored, additional continuing education, reimburse Board cost of invest
Approved on 06/2001-DSO Brad Roberts, DDS-President Dr Champagne-attorney-Hunt- (not reportable to NPDB)

Michael Khanna, DDS

Stipulation- verify licenses and receive written notification from the Board for a period of 5 years, reimburse the Board cost of invest, stipulation is not to be considered discipline or reported as a disciplinary matter
Approved on 07/2005-DSO Stephen Sill, DMD-President Tony Guillen, DDS-attorney-Hunt (not reportable to NPDB)

John Hastings, DDS

Stipulation-practiced monitored, re-take JP Exam, reimburse Board cost of invest, Stipulation states NOT REPORTABLE TO NPDB
Approved on 05/2006 DSO James Kinard, DDS-President Tony Guillen, DDS-attorney Hunt (not reportable to NPDB)

Suzan Fu, DDS

Stipulation- practiced monitored, daily logs, additional continuing education, reimburse Board cost of invest, reimburse patient
Approved 10/2009-DSO Dennis Arch, DDS-President William Pappas, DDS attorney Hunt (not reportable to NPDB)

Terrie Kinnee, DDS

Stipulation- practice monitored, daily logs, additional continuing education, reimburse Board cost of invest, reimburse patient
Approved 06/2010-DSO Byron Blasco, DMD President William Pappas, DDS attorney Hunt (not reportable to NPDB)

Leonid Banchik, DMD

Stipulation-practice monitored, daily logs, additional continuing education, reimburse Board cost of invest, reimburse patients, stipulation uses term "CORRECTIVE".
Approved on 10/2011-DSO Byron Blasco, DMD, President William Pappas, DDS attorney Hunt (not reportable to NPDB)

EXHIBIT
C

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Resources and Services Administration

Bureau of Health Professions — Rockville, MD 20857

FEB 0 2 2011

Kathleen Kelly
Executive Director
Nevada State Board of Dental Examiners
6010 South Rainbow Boulevard
Suite A-1
Las Vegas, Nevada 89118

FEB 04 2011
N.S.B.D.E.

RE: Dentists

Dear Ms. Kelly:

The Health Resources and Services Administration, Division of Practitioner Data Banks (DPDB) is committed to partnering with State licensing and certification boards to encourage the comprehensive review of the professional credentials of health care professionals, and to address patient safety, fraud and abuse in the health care delivery system. To this end the DPDB has undertaken a comprehensive review of the adverse actions that State licensing and certification boards submit to the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank (Data Banks).

The DPBD review encompassed a multistep process, which included reviewing adverse actions publicly posted on licensing and certification board websites, assessing adverse actions provided to the DPDB by these entities, and comparing these data against the actions reported to the Data Banks.

Having completed our comparison of the data available through your organization with the reports that have been submitted to the Data Banks for the years 2006-2009, our objective is to collaborate with licensing and certification boards to ensure that the information in the Data Banks is complete and accurate. Thank you for the assistance you have provided us to date. We welcome your continued cooperation.

From our review, it appears that there are actions/individuals that have not been reported to the Data Banks as required. We have attached a spreadsheet that contains the details of our analysis.

In order to finalize our analysis, we request that you immediately review the outstanding actions listed on the attached spreadsheet. Within 30 calendar days the following next steps are required to ensure that your organization meets Data Banks reporting requirements.

a) Report the actions as required and provide notice to DPDB that you have done so;
b) Supply a written explanation stating the reason that the actions do not meet the reporting requirements; or
c) Provide a Corrective Action Plan (CAP) detailing how your Board will meet Data Banks reporting requirements. The CAP must include provisions for the State licensing or certification board to begin submitting missing data within 15 days of submission of the CAP, an estimate of when all missing data will be reported and the steps that will be taken to ensure that future actions are reported as required.

The results of this DPDB review, along with updates on prior compliance efforts will be posted on the Data Banks website at http://www.npdb-hipdb.hrsa.gov/news/temp/reportingCompliance.jsp on April 1, 2011. It is our goal to help you achieve "compliant" status. Your timely response to this request will help ensure that your organization's reporting compliance is noted accurately and that the Data Banks data are complete. Failure to reply or submit the requested information within 30 days of the date of this letter will result in the Secretary of Health and Human Services naming your organization as "non-compliant" with Data Banks reporting requirements on the NPDB public website.

If you require assistance on Data Banks reporting requirements, please visit our website at: www.npdb-hipdb.hrsa.gov. The website contains the statutes and regulations that pertain to reporting requirements, as well as fact sheets and responses to *Frequently Asked Questions* that may guide your efforts. You may also contact the Customer Service Center at (800) 767-6732 or help@npdb-hipdb.hrsa.gov to request assistance or to obtain a data file (free of charge) containing all actions your organization has reported to the Data Banks.

Please send all requested information directly to Margarita Morales, Compliance Coordinator, at mmorales@hrsa.gov. If you have any questions, please contact Ms. Morales at (301) 443-2300. If you choose to communicate with us via U.S. Mail, our mailing address is: Division of Practitioner Data Banks, 5600 Fishers Lane, Room 8-103, Rockville, MD 20857. . . .

Thank you for reporting your disciplinary actions to the Data Banks as required. We appreciate your continued efforts to meet our joint mission of protecting the public by ensuring that the information in the Data Banks is accurate and complete.

Sincerely,

Cynthia Grubbs

Cynthia Grubbs, R.N., J.D.
Director
Division of Practitioner Data Banks

Enclosure

FEB 04 2011
N.S.B.D.E.

First Name	Last Name	Middle	Suffix	Upload Number	Licensure State	Profession Code	Profession Category	Disciplinary Action Date
Ilya	Benjamin			3724	NV	030 - Dentist	Dentist	06/21/2007
Gregory	Bowman			2880	NV	030 - Dentist	Dentist	03/13/2008
Sebastien	Glaze			4804T	NV	030 - Dentist	Dentist	01/17/2008
Duff	Kester			7357	NV	030 - Dentist	Dentist	01/24/2006
Todd	Krempel	J.		2640	NV	080 - Dentist	Dentist	04/01/2008
Todd	Krempel	J.		2640	NV	080 - Dentist	Dentist	10/30/2008
Adn	Louie-Nont			5463	NV	080 - Dentist	Dentist	06/21/2007
Frank	Nguyen	D.		3365	NV	080 - Dentist	Dentist	05/13/2008
Tri	Nguyen			4368	NV	030 - Dentist	Dentist	01/24/2008
Daniel	Pelk				NV	030 - Dentist	Dentist	05/02/2008
Gerald	Rampton	P.		2337	NV	030 - Dentist	Dentist	11/09/2006
Bradley	Rowe			3470	NV	030 - Dentist	Dentist	06/21/2007
Adrian	Ruiz			4480	NV	030 - Dentist	Dentist	10/30/2006
Mohammad	Soltani	H.		3573	NV	030 - Dentist	Dentist	01/17/2008
Samuel	Thomas			4301	NV	030 - Dentist	Dentist	11/01/2007
John	Vennochi				NV	080 - Dentist	Dentist	06/27/2008
Them	Vu			3781	NV	030 - Dentist	Dentist	01/24/2006
Sufia	Wali				NV	030 - Dentist	Dentist	06/27/2008

FEB 04 2011
N.S.B.D.E.

RALEIGH & HUNT, P.C.

Attorneys at Law

500 South Rancho Drive, Suite 17
Las Vegas, Nevada 89106
702.436.3835
702.436.3836 facsimile

March 3, 2011

Cynthia Grubbs, R.N., J.D., Director
c/o Margarita Morales, Compliance Coordinator
Division of Practitioner Data Banks
5600 Fishers Lane, Room 8-103
Rockville, MD 20857

Re: Correspondence dated February 2, 2011

Coordinator Morales:

Our firm represents the legal interests of the Nevada State Board of Dental Examiners. Please be advised that I am in receipt of Director Grubbs correspondence dated February 2, 2011.

I have reviewed the reference Stipulations identified in the enclosure listing the stipulations that were entered into with the Board. I have also had the opportunity to review the correspondence and the list with Debra Shaffer, the Deputy Executive Director of the Nevada State Board of Dental Examiners. As a result of our review the following response is offered.

As to the stipulations entered into with following:

1. Ilya Benjamin, (Action Date: 06/21/2007)
2. Gregory Bowman, (Action Date: 03/13/2008)
3. Sebastian Glaze, (Action Date: 01/17/2008)
4. Frank Nguyen, (Action Date: (Action Date: 03/18/2008)
5. Bradley Rowe, (Action Date: 06/21/2007)
6. Adrian Ruiz, (Action Date: 10/30/2008)
7. Mohammad Soltani, (Action Date: 01/17/2008)
8. Samuel Thomas, (Action Date: 11/01/2007)
9. Liem Vu, (Action Date: 01/24/2006)
10. Sufia Wali, (Action Date: 06/27/2008)
11. Daniel Paik, (Action Date: 05/02/2008)

In determining whether or not to report those actions as adverse actions, Chapter E Report of the NPDB guidebook E-24 dated September 2001 was considered which is attached for your reference.

None of the stipulations indentified above (1-11) resulted in either a fine, revocation, suspension, censure, reprimand, probation nor was there a surrender of licensure pending disciplinary action. In addition, none of the settlements indentified above in any way restricted the dentist practice. Therefore it is our understanding the Stipulations (1-11) identified above were not adverse actions, but were corrective actions not require reporting. Please advise as to whether our understanding is correct.

Also be advised the HRSA guidelines issued on February 25, 2010, effective March 1, 2010 have been taken into consideration for any actions taken after March 1, 2010. I note that none of the stipulations identified in the correspondence involved stipulations that were entered into the Board subsequent to March 1, 2010.

As to the actions listed below (1-5) according to the Board's Deputy Executive Director it is her recollection during the applicable time frames she submitted temporary adverse action reports with the understanding these temporary adverse action reports would automatically be converted to permanent adverse reports. After review your correspondence it appears the following actions below were not converted into permanent adverse action reports. The Deputy Executive Director now knows it is her responsibility to convert temporary adverse action reports to permanent adverse action reports. Therefore the Board's Corrective Action Plan will be to submit adverse actions reports on the dentist listed below within fifteen days of submission of this correspondence.

1. Duff Kaster, (Action Date: 01/24/2006)
2. Todd Krempel, (Action Date: 10/30/2008)
3. Arin Lousing-Nont, (Action Date: 06/21/2007)
4. Tri Nguyen, (Action Date: 01/24/2006)
5. John Vennochi, (Action Date: 06/27/2008)
6. Gerald Rampton, (Action Date: 11/09/2006)

Lastly as is relates to Todd Kempel (Action Date: 04/01/2008) according to the Board records an adverse action was filed with the National Practitioners Data Bank on April 18, 2008, DCN #5500000050588173.

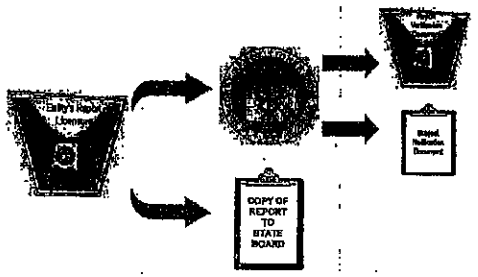
I hope this correspondence has answered all of the inquiries set forth in your correspondence. If you have any further questions, please do not hesitate to call.

Very truly yours,

John A. Hunt, Esq.
Board Counsel

JAH:pc
Enclosures as Stated
cc: Kathleen Kelly, Executive Director
Debra Shaffer, Deputy Executive Director

REPORTING ADVERSE LICENSURE ACTIONS



Reporting Adverse Licensure Actions

State medical and dental licensing boards must report adverse actions against physicians and dentists to the NPDB within 30 days from the date an adverse licensure action was taken.

State medical and dental boards must report to the NPDB certain disciplinary actions related to professional competence or professional conduct taken against the licenses of physicians or dentists. Such licensure actions include revocation, suspension, censure, reprimand, probation, and surrender. State medical and dental boards must also report revisions to adverse licensure actions, such as reinstatement of a license.

Effective Date of Action

An Adverse Action Report must be submitted within 30 days of the date of the formal approval of the licensure action by the State medical or dental board or its authorized official. Significant delays may occur between the formal approval of the action and the drafting of the order for publication; however, the trigger date for reporting the adverse action is based on the board's formal approval of the action.

Examples of Reportable Actions

The following adverse licensure actions, when related to the professional competence or professional conduct of a physician or dentist, must be reported to the NPDB:

- Denial of an application for license renewal.
- Withdrawal of an application for license renewal (should be reported as a voluntary surrender).
- Licensure disciplinary action taken by a State board against one of its licensees/applicants for licensure renewal based upon a licensure disciplinary action, related to the practitioner's professional competence or professional conduct, taken by another State board.

- Licensure disciplinary action taken by a State board based upon the practitioner's deliberate failure to report a licensure disciplinary action taken by another State board, when a report of such action is requested on a licensure renewal application.
- Fines and other monetary sanctions accompanied by other licensure action, such as revocation, suspension, censure, reprimand, probation, or surrender.

Examples of Non-Reportable Actions

The following adverse licensure actions should not be reported to the NPDB:

- Fines and other monetary sanctions unaccompanied by other licensure action, such as revocation, suspension, censure, reprimand, probation, or surrender.
- Denial of an initial application for license.
- A settlement agreement which imposes monitoring of a practitioner for a specific period of time, unless such monitoring constitutes a restriction of the practitioner's license or is considered to be a reprimand.
- A licensure disciplinary action which is imposed with a "stay" pending completion of specific programs or actions. However, if a "stay" of a disciplinary action is accompanied by probation, the probation is reportable.
- Voluntary relinquishment of a physician's license for personal reasons not related to his or her professional competence or professional conduct (for example, retirement).
- Licensure actions taken against non-physician, non-dentist, health care practitioners.

What is Reportable to the NPDB with Section 1921?

Non-Reportable Actions:

- Monitoring, Continuing Education, completion of other obligations (unless it constitutes a restriction, a reprimand, etc...)
- Stayed actions
- Voluntary relinquishment of license for personal reasons (e.g., retirement or change to inactive status)

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Resources and Services Administration

Bureau of Health Professions — Rockville, MD 20857

MAY 25 2011

MAY 27 2011
N.S.B.D.E.

Ms. Kathleen Kelly
Executive Director
Nevada State Board of Dental Examiners
6010 S. Rainbow Boulevard, Suite A-1
Las Vegas, Nevada 89118

Dear Ms. Kelly:

On behalf of the Health Resources and Services Administration (HRSA), Bureau of Health Professions, Division of Practitioner Data Banks (DPDB), I would like to thank you and your organization for the support and assistance you provided during our recent Adverse Licensure Action Comparison Project. The project provided for a comprehensive review of publicly available records of adverse actions against the reports in the National Practitioner Data Bank (NPDB) and Health Integrity Protection Data Bank (HIPDB), collectively known as the "Data Bank."

During the past year, we requested that your organization review and reconcile certain adverse actions for the years 2006-2009. Our review revealed that the actions in question had either not been reported, or were incorrectly reported to the Data Bank. As a direct result of your participation in this reconciliation process, you have furthered our national efforts to ensure that the information in the Data Bank is accurate, complete, and available.

We commend your organization for the success of this effort. By meeting the Data Bank reporting requirements, your organization has attained 'Compliant' status. The results of April 1, 2011, Adverse Licensure Action Comparison Project, along with updates on other compliance efforts are posted on Data Bank website at: http://www.npdb-hipdb.hrsa.gov/news/reportingCompliance.jsp.

Should you require additional assistance on Data Bank reporting requirements, please visit our website at: http://www.npdb-hipdb.hrsa.gov/index.jsp. The website contains the statutes and regulations that pertain to reporting requirements, as well as fact sheets and responses to *Frequently Asked Questions* that may guide your efforts. You may also contact the Customer Service Center at (800) 767-6732 or help@npdb-hipdb.hrsa.gov, or contact our office directly at (301) 443-2300 to request assistance.

The Department of Health and Human Services is dedicated to patient safety for all citizens. We appreciate your ongoing efforts to keep your Board's reporting current with the Data Bank. We look forward to working with you again in the future, and we thank you for your full commitment to patient safety and health care excellence.

Sincerely,

Cynthia Grubbs

Cynthia Grubbs, R.N., J.D.
Director
Division of Practitioner Data Banks

Exhibit 2

Exhibit 2

the DataBank
NATIONAL PRACTITIONER
HEALTHCARE INTEGRITY & PROTECTION

Health Care Organizations

Reporting

Reporting Compliance Status of Government Agencies

U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) has undertaken efforts to improve the completeness and accuracy of data reported to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB). The Secretary of HHS is exercising legal authority as defined under Section 1128E(b)(6)(B) of the Social Security Act to publish a report listing Government agencies that have failed to meet their HIPDB reporting requirements.

For more information about the reporting compliance process and definitions of terms, see About Reporting Compliance.

The following tables include the compliance status as of December 1, 2011 for Government Agencies contacted for the Adverse Action Comparison Project and Never Reported Professions Compliance Effort. The tables include only those States and professions that HRSA has reviewed or is currently reviewing. The compliance status listed in the tables are one of five possible determinations: Compliant, Non-Compliant, Working Toward Compliance, Under Review, or Not Reviewed.

Adverse Licensure Action Comparison Project

For this compliance effort HRSA compared publicly available disciplinary licensure actions published on State web sites for certain years with data currently stored in the HIPDB. HRSA contacted Government agencies with the results of the comparison and sent letters indicating which actions were not found in the Data Banks and requested agencies review these and report as appropriate.

- View Status of Comparison Project

AL | AK | AZ | AR | CA | CO | CT | DE | DC | FL | GA | HI | ID | IL | IN | IA | KS | KY
LA | ME | MD | MA | MI | MN | MS | MO | MT | NE | NV | NH | NJ | NM | NY | NC | ND
OH | OK | OR | PA | RI | SC | SD | TN | TX | UT | VT | VA | WA | WV | WI | WY

State/Agency Professions	Status as of 7/1/2010	Status as of 10/1/2010	Status as of 4/1/2011	Status as of 7/1/2011	Status as of 10/1/2011	Status as of 12/1/2011
Allopathic and Osteopathic	Reviewed	Reviewed	Compliant	Compliant	Compliant	Compliant
Physician Assistant	Under Review	Under Review	Working Toward Compliance	Compliant	Compliant	Compliant
Podiatrist	Under Review	Under Review	Working Toward Compliance	Compliant	Compliant	Compliant
Psychologist	Under Review	Under Review	Working Toward Compliance	Compliant	Compliant	Compliant
Social Worker	Not Reviewed	Compliant	Compliant	Compliant	Compliant	Compliant
Back to Top						
Nevada	Status as of 7/1/2010	Status as of 10/1/2010	Status as of 4/1/2011	Status as of 7/1/2011	Status as of 10/1/2011	Status as of 12/1/2011
Chiropractor	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	Compliant	Compliant
Dentist	Not Reviewed	Not Reviewed	Compliant	Compliant	Compliant	Compliant
Nursing Related Professions	Working Toward Compliance	Working Toward Compliance	Compliant	Compliant	Compliant	Compliant
Optometrist	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	Compliant	Compliant
Pharmacist	Under Review	Compliant	Compliant	Compliant	Compliant	Compliant
Physical Therapist	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	Working Toward Compliance	Compliant
Physician - Allopathic	Not Reviewed	Not Reviewed	Compliant	Compliant	Compliant	Compliant
Physician - Osteopathic	Not Reviewed	Not Reviewed	Compliant	Compliant	Compliant	Compliant
Physician Assistant	Under Review	Compliant	Compliant	Compliant	Compliant	Compliant
Podiatrist	Under Review	Under Review	Compliant	Compliant	Compliant	Compliant
Psychologist	Under Review	Compliant	Compliant	Compliant	Compliant	Compliant
Social Worker	Under Review	Under Review	Compliant	Compliant	Compliant	Compliant

Allopathic and Osteopathic	Reviewed	Reviewed	Compliant	Compliant	Compliant	Compliant
Physician Assistant	Under Review	Under Review	Working Toward Compliance	Compliant	Compliant	Compliant
Podiatrist	Under Review	Under Review	Working Toward Compliance	Compliant	Compliant	Compliant
Psychologist	Under Review	Under Review	Working Toward Compliance	Compliant	Compliant	Compliant
Social Worker	Not Reviewed	Compliant	Compliant	Compliant	Compliant	Compliant
Back to Top						
Nevada	Status as of 7/1/2010	Status as of 10/1/2010	Status as of 4/1/2011	Status as of 7/1/2011	Status as of 10/1/2011	Status as of 12/1/2011
Chiropractor	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	Compliant	Compliant
Dentist	Not Reviewed	Not Reviewed	Compliant	Compliant	Compliant	Compliant
Nursing Related Professions	Working Toward Compliance	Working Toward Compliance	Compliant	Compliant	Compliant	Compliant
Optometrist	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	Compliant	Compliant
Pharmacist	Under Review	Compliant	Compliant	Compliant	Compliant	Compliant
Physical Therapist	Not Reviewed	Not Reviewed	Not Reviewed	Not Reviewed	Working Toward Compliance	Compliant
Physician - Allopathic	Not Reviewed	Not Reviewed	Compliant	Compliant	Compliant	Compliant
Physician - Osteopathic	Not Reviewed	Not Reviewed	Compliant	Compliant	Compliant	Compliant
Physician Assistant	Under Review	Compliant	Compliant	Compliant	Compliant	Compliant
Podiatrist	Under Review	Under Review	Compliant	Compliant	Compliant	Compliant
Psychologist	Under Review	Compliant	Compliant	Compliant	Compliant	Compliant
Social Worker	Under Review	Under Review	Compliant	Compliant	Compliant	Compliant

Entity: NEVADA STATE BOARD OF DENTAL EXAMINERS (LAS VEGAS, NV) | User: Kugeld14 Sign Out

OCCUPATION/FIELD OF LICENSURE CODES

the DataBank
NATIONAL PRACTITIONER HEALTHCARE INTEGRITY & PROTECTION

Please select the code that best describes the subject's occupational activities or licensure category associated with the adverse action being reported.

- Physician
- Nurse - Advanced, Registered, Vocational or Practical
- Nurse Aide, Home Health Aide And Other Aide
- Dental Service Practitioner
  - Dentist
  - Dental Resident
  - Dental Assistant
  - Dental Therapist/Dental Health Aide
  - Dental Hygienist
  - Denturist
- Chiropractor
- Counselor
- Dietician/Nutritionist
- Emergency Medical Technician (EMT)
- Eye and Vision Service Practitioner
- Pharmacy Service Practitioner
- Physician Assistant
- Podiatric Service Practitioner
- Psychologist/Psychological Assistant
- Rehabilitative, Respiratory and Restorative Service Practitioner
- Social Worker
- Speech, Language and Hearing Service Practitioner
- Technologist/Technician
- Other Health Care Practitioner
- Health Care Facility Administrator
- Other Occupation

Continue

Return to Options

Exhibit 3

Exhibit 3

Code of Federal Regulations (CFR) re: the National Practitioner Data Bank (42 USC 11101-11152)

Regulation section	Discussion/Comment
45 CFR 60.3 – Definition *Adversely affecting* means reducing, restricting, suspending, revoking, or denying clinical privileges or membership in a health care entity.	As noted below, this phrase "adversely affecting" is used at 45 CFR 60.11(a)(i) regarding action taken by a health care entity that must be reported to a Board. See discussion below. It is important to note, that this phase "adversely affecting" is not included in the specific types of actions delineated to be reported by a Board to the NPDB, as referenced at 45 CFR 60.8. See discussion below. Moreover, the definition of "adversely affecting" only includes reference to clinical privileges or membership in a health care entity. Again, the definition does not include any reference to a license issued by a Board.
45 CFR 60.3 – Definition *Board of Medical Examiners, or Board,* **means a body or subdivision of such body which is designated by a State for the purpose of licensing, monitoring and disciplining physicians or dentists. This term includes** a Board of Osteopathic Examiners or its subdivision, **a Board of Dentistry or its subdivision,** or an equivalent body as determined by the State. Where the Secretary, pursuant to section 423(c)(2) of the Act, has designated an alternate entity to carry out the reporting activities of §60.11 due to a Board's failure to comply with §60.8, the term Board of Medical Examiners or Board refers to this alternate entity. (Bold emphasis added.)	This definition is important because there is a specific reference to "Board" which includes a Board of Dentistry. This becomes important later when looking at the other various sections regarding what and who has an obligation to report certain action but not other action. See for example, 45 CFR 60.8, as discussed below.
45 CFR 60.3 – Definition *State* means the fifty States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.	It is important to note that there is a definition for "State." Because, at a minimum, there is a definition of "State" and a definition of "Board" and the definitions are obviously different, it becomes important later when looking at the other various sections regarding what and who has an obligation to report certain action and not other action.
45 CFR 60.3 – Definition *Negative action or finding* by a State licensing authority, peer review organization, or private accreditation entity means: (a) A final determination of denial or termination of an accreditation status from a private accreditation entity that indicates a risk to the safety of a patient(s) or	This definition of "negative action or finding" becomes important because it is used in certain other sections below but NOT other sections below. Importantly, at 45 CFR 60.8 which specifically deals with what licensure actions taken by Boards that Boards must report, it does not reference "negative action or

Regulation section	Discussion/Comment
quality of health care services; (b) Any recommendation by a peer review organization to sanction a health care practitioner, physician, or dentist; or (c) Any negative action or finding that under the State's law is publicly available information and is rendered by a licensing or certification authority, including, but not limited to, limitations on the scope of practice, liquidations, injunctions and forfeitures. This definition excludes administrative fines or citations, and corrective action plans, unless they are: (1) Connected to the delivery of health care services, or (2) Taken in conjunction with other licensure or certification actions such as revocation, suspension, censure, reprimand, probation, or surrender.	findings." So, Boards, pursuant 45 CFR 60.8 are not required to report matters falling under the definition of "negative action or finding." Rather, as noted at 45 CFR 60.8 (see discussion below), the Board is mandated to report to the NPDB only three 3 types or categories of action. None of those three specific subsections found at 45 CFR 60.8 is there reference to the phrase "negative action or finding."
45 CFR 60.5 - When information must be reported. Information required under §§60.7, 60.8, and 60.11 must be submitted to the NPDB within 30 days following the action to be reported, beginning with actions occurring on or after September 1, 1990, and information required under §§60.9 and 60.10 must be submitted to the NPDB within 30 days following the action to be reported, beginning with actions occurring on or after January 1, 1992, as follows: (a) *Malpractice Payments (§60.7).* Persons or entities must submit information to the NPDB within 30 days from the date that a payment, as described in §60.7, is made. If required under §60.7, this information must be submitted simultaneously to the appropriate State licensing board. (b) *Licensure Actions (§60.8 and §60.9).* The Board of Medical Examiners or other licensing or certifying authority of a State must submit information within 30 days from the date the licensure action was taken. (c) *Negative Action or Finding (§60.10).* Peer review organizations, or private accreditation entities must report any negative actions or findings to the State within 15 days from the date the action was taken or the finding was made. Each State, through the adopted system of reporting, must submit to the NPDB the information received from the peer review organization or private accreditation entity within 15 days from the date on which it received this information.	45 CFR 60.5(b) provides that Boards are to submit information within 30 days. It should be noted that nowhere does this section dealing with what a Board is to report does it state a Board is to report "negative action or findings." This is important because, as addressed below regarding 45 CFR 60.5(c), the phrase "negative action or finding" is specifically utilized 45 CFR 60.5(c) is important because it specifically uses the phrase "negative action or finding" which, as noted above, is defined in the "definitions" section found 45 CFR 60.3. More importantly, it should be noted that with respect to "negative action or finding," 45 CFR 60.5(c) requires "[p]eer review organizations, or private accreditation entities must report any negative actions or findings to the State within 15 days from the date the action was taken or the finding was made." This can be seen as significant because it specifically does note mandate a Board is to report "negative action or finding." Also, the reports of "negative action or finding" taken by peer review organizations or private accreditation entities are to be reported to "the State." Again, as noted above, "State" is defined as something different than "Board."

Regulation section	Discussion/Comment
(d) *Adverse Actions (§60.11).* A health care entity must report an adverse action to the Board within 15 days from the date the adverse action was taken. The Board must submit the information received from a health care entity within 15 days from the date on which it received this information. If required under §60.11, this information must be submitted by the Board simultaneously to the appropriate State licensing board in the State in which the health care entity is located, if the Board is not such licensing Board.	
45 CFR 60.8 Reporting licensure actions taken by Boards of Medical Examiners. (a) What actions must be reported. Each Board of Medical Examiners must report to the NPDB any action based on reasons relating to a physician's or dentist's professional competence or professional conduct: (1) Which revokes or suspends (or otherwise restricts) a physician's or dentist's license, (2) Which censures, reprimands, or places on probation a physician or dentist, or (3) Under which a physician's or dentist's license is surrendered.	This section mandates what a Board is to report. This section specifically sets forth three (3) categories of action by a Board which must be reported. It is important to note that nowhere in 45 CFR 60.8 (again, this is the section which specifically pertains to what a Board is to report) does it use the phrase "negative action or finding" as defined at 45 CFR 60.3.
45 CFR 60.9 Reporting licensure actions taken by States. (a) What actions must be reported. Each State is required to adopt a system of reporting to the NPDB actions, as listed below, which are taken against a health care practitioner, physician, dentist, or entity (as defined in §60.3). The actions taken must be as a result of formal proceedings (as defined in §60.3). The actions which must be reported are: (1) Any adverse action taken by the licensing authority of the State as a result of a formal proceeding, including revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation; (2) Any dismissal or closure of the formal proceeding by reason of the health care practitioner, physician, dentist, or entity surrendering the license, or the	This section deals with what actions taken by a State that must be reported. Again, as noted above, "State" is defined differently from "Board" and, as a consequence, this section does not pertain or relate to the Dental Board or actions that it may take. Also, with respect to 45 CFR 60.9(a)(4), while it references the reporting to a State "negative action or finding" it relates to only "negative action or finding" taken by entities other than a "Board."

Regulation section	Discussion/Comment
practitioner leaving the State or jurisdiction; (3) Any other loss of the license of the health care practitioner, physician, dentist, or entity, whether by operation of law, voluntary surrender (excluding those due to non-payment of licensure renewal fees, retirement, or change to inactive status), or otherwise; and (4) Any negative action or finding by such authority, organization, or entity regarding the health care practitioner, physician, dentist, or entity.	
45 CFR 60.10 Reporting negative actions or findings taken by peer review organizations or private accreditation entities. (a) What actions must be reported. Each State is required to adopt a system of reporting to the NPDB any negative actions or findings (as defined in §60.3) which are taken against a health care practitioner, physician, dentist, or entity by a peer review organization or private accreditation entity. The health care practitioner, physician, dentist, or entity must be licensed or otherwise authorized by the State to provide health care services. The actions taken must be as a result of formal proceedings (as defined in §60.3).	This section deals with what actions taken by peer review organizations or private accreditation entities. Again, as noted above, peer review organizations or private accreditation entities do not fall within the definition of "Board" and, therefore, this section does not apply to a Board. Also, it is important to note that this section sets forth what action is to be reported by peer review organizations or private accreditation entities. Instead of listing three (3) specific types of actions which must be reported, like with a Board as found at 45 CFR 60.8 as addressed above, this section instead requires peer review organizations or private accreditation entities to report "any negative actions or findings." Again, it is important to note that this phrase ("negative actions or findings") is used here in this section but is not used in the section dealing with what a Board is required to report. It is important to note if a Board was required to report "negative actions or findings" then the regulations could have mandated such a requirement at 45 CFR 60.8. They do not mandate such of the Board. Therefore, the Board is not required to report "negative actions or findings" (again, as defined at 45 CFR 60.3), unlike peer review organizations or private accreditation entities, which are required to do so pursuant to this section, i.e., 45 CFR 60.10.
45 CFR 60.11 Reporting adverse actions on clinical privileges. (a) Reporting to the Board of Medical Examiners — (1) Actions that must be reported and to whom the report must be made. Each health care entity must report to the Board of Medical Examiners in the State	This section mandates what actions taken by a "heath care entity" (which is also defined at 45 CFR 60.3) must be reported to a Board. This section does not deal with what action by a Board must be reported to the NPDB. Those requirements are noted at 45 CFR 60.8.

Regulation section	Discussion/Comment
in which the health care entity is located the following actions: (i) Any professional review action that adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days; (ii) Acceptance of the surrender of clinical privileges or any restriction of such privileges by a physician or dentist— (A) While the physician or dentist is under investigation by the health care entity relating to possible incompetence or improper professional conduct, or (B) In return for not conducting such an investigation or proceeding; or (iii) In the case of a health care entity which is a professional society, when it takes a professional review action concerning a physician or dentist.	

Exhibit 4

Exhibit 4

Code of Federal Regulations (CFR) re: Healthcare Integrity and Protection Data Bank (42 USC 1320a-7e)

Regulation section	Discussion/Comment
45 CFR 61.3 Definitions. *Any other negative action or finding* by a Federal or State licensing agency means any action or finding that under the State's law is publicly available information, and rendered by a licensing or certification authority, including but not limited to, limitations on the scope of practice, liquidations, injunctions and forfeitures. This definition also includes final adverse actions rendered by a Federal or State licensing or certification authority, such as exclusions, revocations or suspension of license or certification that occur in conjunction with settlements in which no finding of liability has been made (although such a settlement itself is not reportable under the statute). **This definition excludes administrative fines or citations and corrective action plans and other personnel actions, unless they are:** **(1) Connected to the delivery of health care services, *and*** **(2) Taken in conjunction with other licensure or certification actions such as revocation, suspension, censure, reprimand, probation or surrender.** (Emphasis added.)	It is important to note that the definition of "any other negative action or finding" specifically states it "excludes administrative fines or citations **and corrective action plans** and other personnel actions, unless they are: (1) Connected to the delivery of health care services, ***and*** (2) Taken in conjunction with other licensure or certification actions such as revocation, suspension, censure, reprimand, probation or surrender." Therefore, in keeping with this definition and its exception, it goes without saying that the stipulated agreements for corrective action entered into by licensees and the Dental Board are corrective action plans which do NOT fall within the definition of "any other negative action or finding." This definition and it exception for corrective action plans is important also because it specifically includes corrective action plans (assuming they meet the two (2) sub-requirements) as being excluded from being defined as "any other negative action or finding." Thus, such a corrective action is not required to be reported. Also, there is an issue regarding whether a Board even falls under the definition of "Federal or State licensing agency" in light of a Board's requirement to report under the NPBD (as opposed to this data bank, the HIPDB).
45 CFR 61.7 Reporting licensure actions taken by Federal or State licensing and certification agencies. (a) *What actions must be reported.* Federal and State licensing and certification agencies must report to the HIPDB the following final adverse actions that are taken against a health care provider, supplier, or practitioner (regardless of whether the final adverse action is the subject of a pending appeal)— (1) Formal or official actions, such as revocation or suspension of a license or certification agreement	This section mandates what "Federal or State licensing and certification agencies" are to report to the HIPDB. This section specifically sets forth three (3) categories of action by a "Federal or State licensing and certification agencies" which must be reported. It is important to note that nowhere in 45 CFR 61.7 (again, assuming the NIPDB pertains to a Board) does it use the phrase corrective action. In fact, as noted above with regards to the definition of "any other negative action or finding"

Regulation section	Discussion/Comment
or contract for participation in Federal or State health care programs (and the length of any such suspension), reprimand, censure or probation; (2) Any other loss of the license or loss of the certification agreement or contract for participation in Federal or State health care programs, or the right to apply for, or renew, a license or certification agreement or contract of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewal (excluding nonrenewals due to nonpayment of fees, retirement, or change to inactive status), or otherwise; and (3) Any other negative action or finding by such Federal or State agency that is publicly available information.	it specifically states it "excludes administrative fines or citations **and corrective action plans** and other personnel actions, unless they are: (1) Connected to the delivery of health care services, ***and*** (2) Taken in conjunction with other licensure or certification actions such as revocation, suspension, censure, reprimand, probation or surrender." Corrective action stipulations as used by the Dental Board can thus be seen as falling within the exception to "any other negative action of finding" and, therefore, are not reportable pursuant to 61.7(a)(3). Again, even if the reporting requirements of the NIPDB apply to a Board. As noted above, there is an issue regarding whether a Board even falls under the definition of "Federal or State licensing agency" in light of a Board's requirement to report under the NPBD (as opposed to this data bank, the HIPDB).

Exhibit 5

Exhibit 5

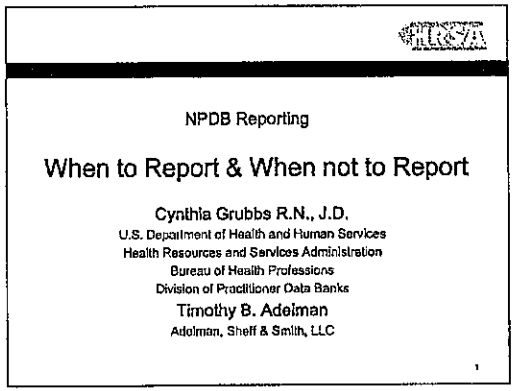
The "HIPDB Guidebook" states at page E-10, in part, for examples of what is NOT REPORTABLE to the HIPDB:

> *Examples of Non-Reportable Actions*
>
> The following adverse licensure actions should *not* be reported to the HIPDB:
>
> - A settlement agreement which imposes the monitoring of a practitioner, provider, or supplier for a specific period of time, unless such monitoring constitutes a restriction on the licensee, or is considered to be a reprimand.

This is consistent with the Board's use corrective action stipulations which have either an additional educational component and/or monitoring component. Such a stipulation for corrective action by the Board does not constitute a restriction on the licensee and/or is not considered to be a reprimand by the Board. Thus, such a stipulation for corrective action is NOT REPORTABLE.

The above is also consistent with a power point presentation by Cynthia Grubbs, R.N., J.D., as addressed below:

Power Point presentation "NPDB Reporting: When to Report & When not to Report"


NPDB Reporting

When to Report & When not to Report

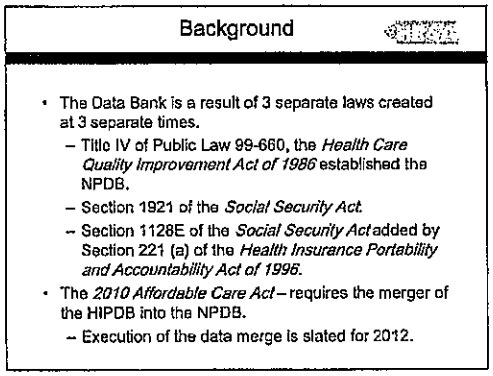
Cynthia Grubbs R.N., J.D.
U.S. Department of Health and Human Services
Health Resources and Services Administration
Bureau of Health Professions
Division of Practitioner Data Banks
Timothy B. Adelman
Adelman, Sheff & Smith, LLC

1

NOTE: Ms. Grubbs is the person who sent to the Board a letter in May 2011 stating the Board was in compliance with the data banks' reporting requirements. The May 2011 letter from Ms. Grubb was sent AFTER a letter was sent on behalf of the Board dated March 3, 2011 (responding to a February 2011 letter from Ms. Grubbs), advising and discussing, in part, corrective action stipulations which were not reported to the data banks. Again, Ms. Grubbs' May 2011 determination the Board was in compliance with the data banks' reporting requirements came AFTER she was advised of the Board's reasoning and basis for its use of corrective action stipulations and why they were not reported to the data banks. AFTER reviewing this information, Ms. Grubbs' May 2011 letter advises the Board it was in compliance with data banks' reporting requirements. This determination by Ms. Grubbs that the Board is in compliance with its reporting to

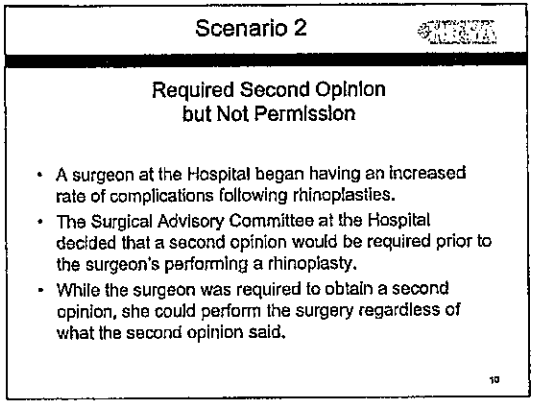
the data banks is confirmed by the data banks website which notes Nevada, Dentist, as being "Compliant" for its status as of 4/1/2011, 7/1/2011, 10/1/2011, and 12/1/2011 (the latest date referenced).

* Ms. Grubbs' power point presentation includes reference to 2010 Affordable Care Act (requires the merger of the HIPDB into the NPDB):

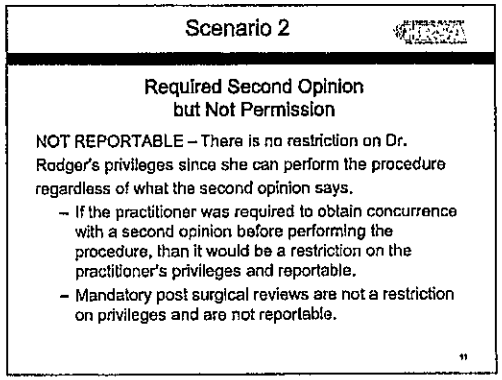


* Ms. Grubbs' power point presentation goes through various factual scenarios and then provides answers to those factual scenarios about whether they need to be reported or don't need to be reported.

* One of the scenarios (Scenario 2) is analogous to the Board's corrective action stipulations which have a monitoring component:



* With regards to whether the action in Scenario 2 was or was not reportable, Ms. Grubbs' power point presentation states:



This factual scenario regarding a requirement of a second opinion but with no requirement that the licensee abide by or seek permission from a second opinion as being NOT REPORTABLE can be seen as analogous to the Board's use of corrective action stipulations which have monitoring or educational components. Under either scenario there is no restriction on the licensee's license/privileges and, therefore, the action is NOT REPORTABLE.

Review of other scenarios in Ms. Grubb's power point presentation reveal that the overriding focus for actions that are to be reported generally have a component where the doctor's privileges are restricted or suspended or there is deemed to be an "adverse action."

Here, with respect to the Board's use of corrective action stipulations which have either an additional educational component and/or monitoring component, such action is akin to the action Ms. Grubb's factual scenarios deem to be NOT REPORTABLE. Afterall, an additional educational component and/or monitoring component are not actions which restrict or suspend a licensee's license and such action is not deemed to be "adverse action." Hence, it is NOT REPORTABLE.

Exhibit 6

"Dear Data Bank" from the May 2012 Newsletter

The website www.npdb-hipdb.hrsa.gov has a page regarding "May 2012 Newsletter." Part of that page has a section entitled "Dear Data Bank" which references questions about Data Bank policies and procedures.

One of the questions reads:

> "If a State Board receives a complaint received about a practitioner, and a Letter of Concern is subsequently issued to the practitioner, would it be reportable to the Data Bank?"

The response, in pertinent part, provides:

> "Some states consider a Letter of Concern to be a publicly available negative action or finding, thereby making it reportable. States that do not consider a Letter of Concern to be a publicly available negative action or finding are not required to report the action."

This "Dear Data Bank" discussion can be seen as also supporting the Board NOT REPORTING stipulation agreements for corrective action because it has been the policy of the Board for years that corrective action is not discipline, not an adverse action, that there is no limiting or restricting of the license, and corrective action stipulations do not impose revocation, suspension, censure, reprimand, probation, or surrender of license.

Moreover, it should not be forgotten that Cynthia Grubbs, R.N., J.D., Director, Division of Practitioner Data Banks, has advised in correspondence from May 2011 the Board is in compliance with its reporting. This determination by Ms. Grubbs came AFTER she received a letter sent on behalf of the Board dated March 3, 2011, advising and discussing, in part, corrective action stipulations which were not reported to the Data Banks. Again, it was AFTER Ms. Grubb was advised of the Board's reasoning and basis for its use of corrective action stipulations and why they were not reported to the NPDB did Ms. Grubb send her letter saying the Board was in compliance with the data banks' reporting requirements.

Exhibit 6

Exhibit 7

Other Boards using corrective action agreements/orders and NOT REPORTING them to the data banks

Certain other Boards in other states also use corrective action agreements/orders and DO NOT REPORT them to the data banks.

For instance, the **Texas Medical Board** (TMB) states, in part, on its website:

> REPORTING DISCIPLINARY INFORMATION
>
> TMB *reports* to the National Practitioner Data Bank all disciplinary actions that place *restrictions on a physician's practice*, as well as any suspension, revocation, or public reprimand. TMB *does not report* to the NPDB actions that only place *requirements on the licensee*, such as participation in a chart monitoring program, extra continuing medical education, or an administrative penalty.
>
> TMB disciplinary actions are also made public. Names and summaries of any type of order approved by the board (agreed order, temporary suspension order, etc) are distributed in news releases, published in the TMB newsletter, the *Texas Medical Board Bulletin*, and are included in the licensee's profile, which is available through the TMB web site. Since *remedial plans* are not disciplinary actions, they are made publicly available on a physician's profile, but are not reported in the newsletter or in press releases.

See www.tmb.state.tx.us/consumer/DisciplinaryProcess.php.

Also, the **Oregon Medical Board** uses "Corrective Action Agreements" which its newsletter/report notes as follows:

> Corrective Action Agreements are not disciplinary orders. They are public agreements with the goal or remediating problems in licensees' individual practices."

The corrective action agreements are not referenced as being reported to the NPDB. In contrast, the Oregon Medical Board also reference the use of "disciplinary orders" which are specifically referenced as being reportable to the NPDB.

Exhibit 7

Further, the **Minnesota Board of Dentistry** references "Agreements for Corrective Action" which are noted as "not considered disciplinary action, and therefore, is not reported to the National Practitioner Data Bank." In particular, the Minnesota Board of Dentistry's website states, in pertinent part:

2. ***Agreement for Corrective Action.***

Purpose: An Agreement for Corrective Action is used (1) to resolve complaints which allege minor violation(s) of the dental practice act, and (2) when the nature of the violation(s) does not warrant disciplinary action.

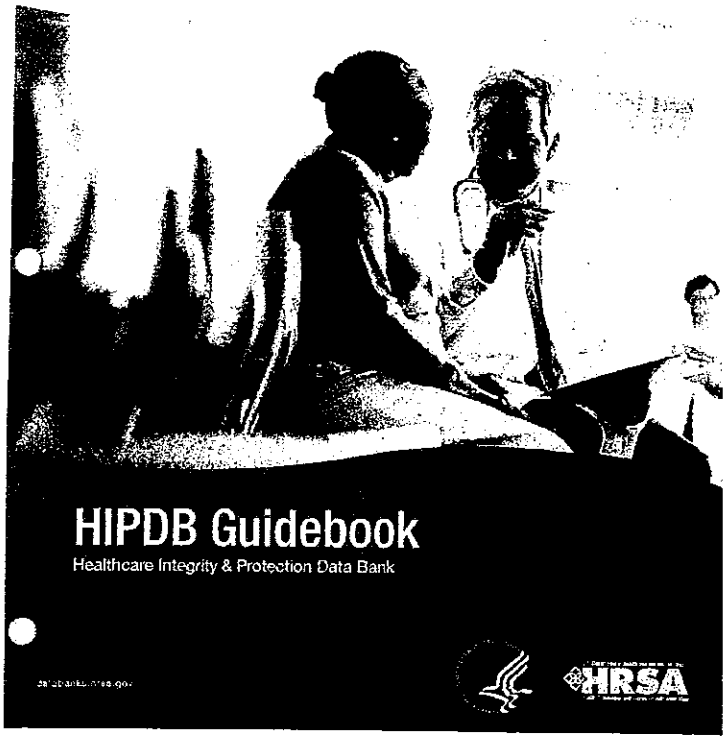
The Agreement for Corrective Action:

a. An Agreement for Corrective Action is expected to lead to dismissal.
b. It is not intended for long-term monitoring or conditions (whereas a Board order may place limits or conditions for long time periods);
c. It is a public agreement, but it is not considered disciplinary action, and therefore, is not reported to the National Practitioner Data Bank.

See www.dentalboard.state.mn.us

the DataBanks

National Practitioner | Healthcare Integrity & Protection



HIPDB Guidebook

Healthcare Integrity & Protection Data Bank

HRSA

Preface

This *Guidebook* is meant to serve as a resource for users of the Healthcare Integrity and Protection Data Bank (HIPDB). It is one of a number of efforts to inform the health care community about the HIPDB and what is required to comply with the requirements established by Section 1128E of the *Social Security Act*, the legislation governing the HIPDB. This *Guidebook* contains information on the HIPDB that governmental agencies (including law enforcement), health plans, and health care practitioners, providers, and suppliers will need to interact with the HIPDB.

Final regulations governing the HIPDB will be published in the *Federal Register* and will be codified at 45 CFR Part 61. Responsibility for HIPDB implementation resides in the U.S. Department of Health and Human Services (DHHS).

The *Guidebook* is divided into broad topical sections. This Introduction contains general information on the HIPDB, which includes its history, the laws and regulations that govern it, and other information for authorized users. The Eligible Entities section describes the organizations that are eligible reporters and queriers. The HIPDB Practitioners, Providers, and Suppliers section defines the subjects of reports submitted to the HIPDB, and provides basic explanations about HIPDB self-queries and report information. The HIPDB Reports section identifies the types of actions that must be reported to the HIPDB, and the Disputes section provides information on the HIPDB dispute process.

Background

Health care fraud burdens the Nation with enormous financial costs and threatens health care quality and patient safety. Estimates of annual losses due to health care fraud range from 3 to 10 percent of all health care expenditures--between $30 billion and $100 billion, based on estimated 1997 expenditures of more than $1 trillion.

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA), Public Law 104-191, enacted August 21, 1996, requires the Secretary of DHHS (Secretary), acting through the Office of Inspector General (OIG) of DHHS and the United States Attorney General, to create a national health care fraud and abuse control program. Among the major components of this program is the establishment of a national data bank to receive and disclose certain final adverse actions against health care practitioners, providers, and suppliers. This data bank is known as the Healthcare Integrity and Protection Data Bank (HIPDB); the legislation which brought it into being also is referred to as Section 1128E of the *Social Security Act* (Section 1128E).

The legislation for the HIPDB stipulates that there be:

- Protection of privacy.
- Civil liability protection.
- Coordination with the National Practitioner Data Bank (NPDB).
- User fees for disclosure of information.
- Regular reports (not less than monthly).
- Dispute procedures.

Elaboration of these provisions are found throughout this *Guidebook*. Explanation of the protection of privacy, civil liability protection, and NPDB coordination are included in the following sections.

Interpretation of HIPDB Information

The purpose of the HIPDB is to combat fraud and abuse in health insurance and health care delivery and to promote quality care. The HIPDB is primarily a flagging system that may serve to alert users that a more comprehensive review of a practitioner's, provider's, or supplier's past actions may be prudent. HIPDB information is intended to be used in combination with information from other sources (e.g., evidence of current competence through continuous quality improvement studies, peer recommendations, verification of training and experience, and relationships with organizations) in making determinations on employment, affiliation, certification, or licensure decisions.

The information in the HIPDB should serve only to alert Government agencies and health plans that there *may* be a problem with a particular practitioner's, provider's, or supplier's performance. HIPDB information should *not* be used as the sole source of verification of a practitioner's, provider's, or supplier's professional credentials.

Confidentiality of HIPDB Information

Information reported to the HIPDB is considered confidential and shall not be disclosed except as specified in the HIPDB regulations at 45 CFR Part 61. The confidential receipt, storage, and disclosure of information is an essential ingredient of HIPDB operations. A comprehensive security system has been designed to prevent manipulation of, and access to the data by unauthorized staff or external sources via the Internet. The facility in which the HIPDB is housed meets DHHS security specifications, and the HIPDB's staff has undergone an in-depth background security investigation.

Persons or entities who receive information from the HIPDB either directly or indirectly are subject to the confidentiality provisions. When an Authorized Agent is designated to handle HIPDB queries or reports, both the entity and the agent are required to maintain confidentiality in accordance with HIPDB requirements.

The *Privacy Act*, 5 USC §552a, protects the contents of Federal systems of records on individuals, like those contained in the HIPDB, from disclosure without the individual's consent, unless the disclosure is for a routine use of the system of records as published annually in the *Federal Register*. The published routine uses of HIPDB information do not allow disclosure to the general public. The limited access provision of Section 1128E of the *Social Security Act* supersede the disclosure requirements of the *Freedom of Information Act* (FOIA), 5 USC §552, as amended.

The confidentiality provisions of Section 1128E do not prohibit an eligible entity receiving information from the HIPDB from disclosing information to others who are part of the investigation or peer review process, as long as the information is used for the purpose for which it was provided.

One example of the appropriate use of HIPDB information is a health plan that discloses the information it received from the HIPDB to health plan officials responsible for reviewing a chiropractor's application for affiliation. In this case, both the health plan personnel who received the information and the health plan officials who subsequently reviewed it during the employment process are subject to the confidentiality provisions of HIPDB.

The confidentiality provisions do not apply to the original documents or records from which the reported information is obtained. The HIPDB's confidentiality provisions do not impose any new confidentiality requirements or restrictions on those documents or records. Thus, these confidentiality provisions do not bar or restrict the release of the underlying documents, or the information itself, by the entity taking the adverse action. For example, if a health plan that reported an adverse action against a chiropractor pursuant to the provisions of the HIPDB receives a subpoena for the underlying records, it may not refuse to provide the requested documents on the grounds that HIPDB bars the release of the records or information.

Individual health care practitioners, providers, and suppliers who obtain information about themselves from the HIPDB are permitted to share that information with whomever they choose.

The statute requires the Secretary to assure that HIPDB information is provided and used in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services. Patient names are not to be submitted in HIPDB reports.

Persons or entities who receive information from the HIPDB either directly or indirectly are subject to the above confidentiality provisions. The statute does not specify a penalty for violating the

confidentiality provisions of the HIPDB. However, other Federal statutes may subject individuals and entities to criminal penalties, including fines and imprisonment, for the inappropriate use or disclosure of HIPDB information.

Official Language

The official language of the HIPDB is English, and all documents submitted to the HIPDB must be written in English. Documents submitted in any other language will not be accepted.

Disclosure of the HIPDB Information

Section 1128E limits the disclosure of information in the HIPDB. HIPDB information is available, upon request, to:

- Federal and State Government agencies.
- Health plans.
- Health care practitioners, providers, and suppliers requesting information concerning themselves.
- Persons or organizations requesting information in a form which does not permit the identification of any particular patient or health care practitioner, provider, or supplier.

The limited access provision of Section 1128E does not allow the disclosure of HIPDB information to the general public.

Civil Liability Protection

The immunity provisions in Section 1128E protect individuals, entities, and their authorized agents from being held liable in civil actions for reports made to the HIPDB unless they have actual knowledge of falsity of the information. The statute provides similar immunity to DHHS in maintaining the HIPDB.

Coordination Between the HIPDB and the NPDB

The NPDB is a national data bank that was established through Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986*, as amended. It is primarily an alert or flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials. The NPDB acts as a clearinghouse of information relating to medical malpractice payments

and adverse actions taken against the licenses, clinical privileges, and professional society memberships of physicians, dentists, and other licensed health care practitioners.

To alleviate the burden on those entities that must report to both the HIPDB and NPDB, a system has been created to allow an entity that must report the same adverse action to both Data Banks to submit the report only once. This Integrated Querying and Reporting System (IQRS) is able to sort the appropriate actions into the HIPDB, the NPDB, or both. Similarly, entities authorized to query both Data Banks have the option of querying both the NPDB and the HIPDB with a single query submission.

All final adverse actions taken on or after August 21, 1996 (the date Section 1128E was passed), must be reported to the HIPDB. The HIPDB cannot accept any report with a date of action taken prior to August 21, 1996.

User Fees

User fees will be charged for all queries for HIPDB information submitted by non-Federal agencies and health plans and for self-queries submitted by health care practitioners, providers, or suppliers. Section 1128E exempts Federal entities from paying these fees. Refer to the NPDB-HIPDB website for details regarding the payment of HIPDB user fees.

What is an Eligible Entity?

Entities eligible to participate in the Healthcare Integrity and Protection Data Bank (HIPDB) are defined in the provisions of Section 1128E of the *Social Security Act* and in the HIPDB Final Rule. Eligible entities are responsible for meeting Section 1128E reporting and/or querying requirements, as appropriate, and must certify in writing their eligibility to report to and/or query the HIPDB.

The HIPDB provides information to entities and individuals who are eligible to receive HIPDB information. The HIPDB collects information regarding licensure and certification actions, exclusions from participation in Federal and State health care programs, criminal convictions, and civil judgments related to health care. While Section 1128E requires the reporting of such adverse actions, there are currently no mandatory querying requirements associated with the HIPDB.

To be eligible to report to and/or query the HIPDB, an entity must be:

- A Federal or State Government agency.
- A health plan.

Each entity is responsible for determining its eligibility to participate in the HIPDB and must certify that eligibility to the HIPDB in writing.

Defining Entities

Federal or State Government Agency

Federal or State Government agencies include, but are not limited to, the following:

- The U.S. Department of Justice (e.g., the Federal Bureau of Investigation, the U.S. Attorney, the Drug Enforcement Administration).
- The U.S. Department of Health and Human Services (e.g., the Food and Drug Administration, the Health Care Financing Administration, the Office of Inspector General).
- Any other Federal agency that either administers or provides payment for the delivery of health care services, including (but not limited to) the U.S. Department of Defense and the U.S. Department of Veterans Affairs.
- Federal and State law enforcement agencies, including States Attorneys General and law enforcement investigators (e.g., County and District Attorneys, County Police Departments).

- State Medicaid Fraud Control Units.
- Federal or State agencies responsible for the licensing or certification of health care practitioners, providers, and suppliers. Examples of such State agencies include Departments of Professional Regulation, Health, Social Services (including State Survey and Certification and Medicaid Single State agencies), Commerce, and Insurance.

Health Plan

The term "health plan" refers to a plan, program or organization that provides health benefits, whether directly or through insurance, reimbursement or otherwise. Entities may be recognized as "health plans" if they meet the basic criterion of "providing health benefits." Health plans include, but are not limited to:

- A policy of health insurance.
- A contract of a service benefit organization.
- A membership agreement with a health maintenance organization or other prepaid health plan.
- A plan, program, or agreement established, maintained, or made available by an employer or group of employers; a practitioner, provider, or supplier group; a third-party administrator; an integrated health care delivery system; an employee welfare association; a public service group or organization; or a professional association.
- An insurance company, insurance service, or insurance organization that is licensed to engage in the business of selling health care insurance in a State, and which is subject to State law which regulates health insurance.

Health plans may include those plans funded by Federal and State governments, including:

- Medicare.
- Medicaid.
- The U.S. Department of Defense.
- The U.S. Department of Veterans Affairs.
- The Bureau of Indian Affairs programs.

Registering with the HIPDB

Eligible entities are responsible for meeting Section 1128E reporting and/or querying requirements. Entities not currently registered with the HIPDB are responsible for determining their eligibility before registering with the HIPDB. The HIPDB issues a Data Bank Identification Number (DBID) and a password to each successfully registered entity. An entity that does not have this information is not registered with the HIPDB. Entity registration packages may be obtained by calling the NPDB-HIPDB Help Line at 1 (800) 767-6732.

The consolidated *Entity Registration Form* allows entities to register simultaneously for both the HIPDB and the NPDB. The information requested on this form provides the HIPDB with essential information concerning your entity, such as your organization's name, address, Federal Taxpayer Identification Number (TIN), and ownership; your organization's authority to participate in the HIPDB and/or the NPDB under each of the statutes governing the Data Banks (Section 1128E for the HIPDB; and Title IV and Section 1921 of the *Social Security Act* for the NPDB); your organization's primary function or service; and, for those entities authorized by law to query both Data Banks, whether queries are to be submitted to the HIPDB only, to the NPDB only, or to both Data Banks. This information allows the HIPDB to register your entity's authorization to participate in the HIPDB, to determine your entity's reporting and/or querying requirements and restrictions, and to direct query and report responses appropriately.

The *Entity Registration Form* also contains certification information that must be completed by an entity's Certifying Official. The entity's Certifying Official certifies the legitimacy of the registration information provided to the HIPDB and/or the NPDB. The certification section must contain an original ink signature and a signature date. Faxed, stamped, or photocopied signatures are unacceptable. The title of the Certifying Official, a telephone number, and an E-mail address also must be provided.

Once the completed *Entity Registration Form* is received and processed, the HIPDB assigns a unique, confidential Data Bank Identification Number (Data Bank ID or DBID) and sends an *Entity Registration Verification* document to the entity. This document contains the entity's confidential DBID and password, as well as the information that was provided to the HIPDB on the *Entity Registration Form*. The Certifying Official should read the document carefully and, if the document contains any errors, follow the instructions provided on the document for correcting the inaccurate information.

HIPDB responses to reports and queries are retrieved via the HIPDB's Integrated Querying and Reporting Service (IQRS). Entities and Agents must log onto the NPDB-HIPDB website to retrieve their report and query responses. Responses that are not viewed or printed within 30 days of being placed by the HIPDB into the IQRS will be deleted, and the entity or Agent will be required to resubmit the information.

Entity Recertification

The HIPDB requires periodic recertification of eligibility by entities. The HIPDB will send the current registration information to each active entity. The entity's Certifying Official should review the information to ensure that it is correct, indicate the applicable certification statement, sign the document, and return it to the HIPDB.

Data Bank Identification Numbers

Each entity that registers with the HIPDB is assigned a unique DBID and password. DBIDs are used by the HIPDB to identify registered entities and Agents, and must be provided on all reports, queries, and correspondence submitted to the HIPDB.

Your entity's DBID is a link into the HIPDB computer system and should be safeguarded to prevent inadvertent disclosure. A DBID is revealed only to the entity or Agent to which it is assigned. In the event that your entity's DBID is compromised, follow the instructions in "Deactivating a Data Bank Identification Number" section below.

The assignment of a DBID is not a representation by HHS that an entity meets the eligibility criteria for participation in the HIPDB, as specified in Section 1128E. It is each entity's responsibility to determine whether it meets the eligibility criteria and to certify that eligibility to the HIPDB.

DBIDs are assigned only to entities that certify their eligibility to the HIPDB and to Authorized Agents who act on behalf of registered entities: ***DBIDs are not assigned to Authorized Submitters or other individuals associated with a reporting or querying entity.***

Deactivating a Data Bank Identification Number

If at any time your entity relinquishes eligibility to participate in the HIPDB, you must notify the HIPDB to deactivate your DBID. The *Entity Registration Update* form, which can be retrieved from the NPDB-HIPDB website, must be completed in order to request deactivation. The reason for deactivation must be provided on the completed form when it is returned to the HIPDB for processing.

An eligible entity, by completing an Entity Registration Update form, may request at any time that its current DBID be deactivated and a new DBID assigned. For instance, if you believe that your entity's DBID has been compromised in any way, or if your entity merges with another entity. The reason for requesting a new DBID must be provided on the completed form when it is returned to the HIPDB for processing.

Reactivating a Data Bank Identification Number

If your entity's DBID is currently inactive and your entity determines that it should be active, the Certifying Official should obtain an *Entity Registration Update* form from our website to request that the DBID be reactivated. The reason for reactivation must be provided on the completed form when it is returned to the HIPDB for processing.

Updating Entity Information

If your entity's name, address, statutory authority, organization type, Certifying Official, or any other item of your registration information changes, your entity's Certifying Official should obtain an *Entity Registration Update* form from our website.

When the HIPDB receives updated entity information, the updated information is processed into the HIPDB computer system and an *Entity Registration Verification* document, reflecting the changes submitted, is mailed to the entity's Certifying Official. The Certifying Official should read the document carefully and, if the document contains any errors, follow the instructions provided on the document for correcting the inaccurate information.

Lost Your Data Bank Identification Number?

If your data become corrupted or you want to deactivate your current DBID and activate a new one, call the NPDB-HIPDB Help Line for assistance.

Individuals Who May Report to and/or Query on Behalf of Entities

Queries and reports may be submitted to, and responses may be retrieved from, the HIPDB on behalf of registered entities by Authorized Submitters or Authorized Agents. These individuals are defined as follows:

Authorized Submitter

An Authorized Submitter is the individual selected and empowered by a registered entity to certify the legitimacy of information reported to or requested from the HIPDB via the IQRS. In most cases, the Authorized Submitter is an employee of the organization submitting the report or query (such as an Administrator, Medical Staff Services Officer, or Risk Manager). An entity may choose to have multiple Authorized Submitters. For example, an entity may designate a particular individual within the organization to be the Authorized Submitter for reporting, and another individual to be the Authorized Submitter for querying. The Authorized Submitter is often the individual designated by the organization to submit and

retrieve report and/or query responses from the HIPDB; however, other response staff personnel may be designated, as desired.

Authorized Agents

Registered entities may elect to have outside organizations report to and/or query the HIPDB on their behalf. An organization that reports to and/or queries the HIPDB on an entity's behalf is referred to as the Authorized Agent. In most cases, an Authorized Agent is an independent contractor to the entity (e.g., National Council of State Boards of Nursing, Federation of Chiropractic Licensing Boards, Credentialing Verification Organization) used for centralized credentialing and/or professional oversight.

Entities must ensure that certain guidelines are followed when designating an Authorized Agent to report and/or query on their behalf. Entities should establish a written agreement with the Agent confirming the following:

- The Agent must be authorized to conduct business in the State.
- The Agent's facilities must be secure to ensure the confidentiality of HIPDB responses.
- The agreement with the Authorized Agent must explicitly prohibit the Agent from using information obtained from the HIPDB for any purpose other than that for which the disclosure was made. For example, two different health plans designate the same Authorized Agent to query the HIPDB on their behalf. Both health plans wish to request information on the same practitioner. The Authorized Agent must query the HIPDB separately on behalf of each health plan. The response to a HIPDB query submitted for one health plan cannot be shared with another health plan.
- The entity should ensure that the Authorized Agent has a copy of the most recent Guidebook (which includes the regulations and the civil money penalty regulations of the Office of Inspector General, HHS, at 45 CFR Part 1003) and should make the Authorized Agent aware of the sanctions that can be taken against the Authorized Agent if information is requested, used, or disclosed in violation of HIPDB provisions.

Designating Authorized Agents

Before an Authorized Agent may act on behalf of an entity, the entity must designate the Agent to interact with the HIPDB on its behalf. Registered entities that want to designate an Authorized Agent should obtain an *Authorized Agent Designation* form from the NPDB-HIPDB website. The entity must complete the form, providing the Authorized Agent's name, DBID (if known), address, and telephone number; and the entity's response routing and fee payment preferences, and return it to the HIPDB.

Authorized Agents must be registered with the HIPDB before they can be designated to report and/or query on behalf of eligible entities. If the Agent is not registered with the HIPDB, the Agent must obtain an *Authorized Agent Registration* form the NPDB-HIPDB website. Once the Agent is registered, a DBID and an electronic mailbox password will be assigned to that Agent, and the entity can designate that Agent to report and/or query on its behalf.

HIPDB responses to reports and queries submitted by an Authorized Agent will be routed to either the eligible entity or its Authorized Agent, as indicated by the entity on the *Authorized Agent Designation* form. If the entity wishes to retrieve responses from the IQRS via its own electronic mailbox, the entity must have access to the Internet (i.e., an Internet Service Provider) and an Internet browser (either Microsoft Internet Explorer or Netscape Communicator, Version 4.0 or newer).

An Authorized Agent should have only one DBID, even though more than one entity may designate the Agent to query the HIPDB. If an Authorized Agent has been issued more than one DBID, the Authorized Agent should obtain an *Agent Registration Update* form from our website, indicating which DBID it intends to use and to request that any other DBIDs be deactivated.

Any changes to an Authorized Agent designation, such as a change to response routing or termination of an Authorized Agent's authorization to query on an entity's behalf, must be submitted by the entity. If changes in an Authorized Agent designation are required, the entity should obtain an *Authorized Agent Designation Update* form from the NPDB-HIPDB website.

Questions and Answers

1. **How do I know if my organization is an eligible entity?**
   To be eligible to participate in the HIPDB, an organization must meet the definition of a Government agency or a health plan, as defined under Section 1128E of the *Social Security Act*. See §61.3, Definitions, of the HIPDB regulations.

2. **Can the HIPDB certify or verify that my organization is eligible to report or query?**
   Each entity must determine its own eligibility to participate in the HIPDB. The HIPDB regulations describe the criteria for eligibility. Other informational materials designed to assist you in determining your organization's eligibility can be found on the NPDB-HIPDB website.

3. **Does my entity have to notify the HIPDB when we have a new Certifying Official?**
   Yes. The eligible entity gives the Certifying Official authority to certify the legitimacy of registration information provided to the HIPDB. The person authorized by the entity to act as the Certifying Official may change at any time at the discretion of the entity. However, the HIPDB makes a record

of the staff title and name of the individual assigned as the Certifying Official and should be notified when changes occur.

4. **Can my organization query the HIPDB if we are not mandated reporters under Section 1128E?**
   No. The statute defines queriers and reporters as the same organizations.

5. **If my entity queries the HIPDB, is it also required to report? Conversely, if my entity reports to the HIPDB, is it automatically eligible to query?**
   Yes. Entities that report to HIPDB are automatically eligible to query.

6. **Is my entity required to query the HIPDB?**
   No. Section 1128E does not set mandatory querying requirements for any entity.

7. **Can my entity have more than one DBID?**
   If you have multiple departments or people who handle HIPDB querying and/or reporting, you may register each department or person separately and receive a separate DBID for each one. However, it should be noted that the different DBIDs cannot help each other (i.e., one department cannot download a response from a query entered by another department with a different DBID). Also, special care must be taken to be sure that the same report or query is not submitted twice.

8. **Which law enforcement agencies will have access to the HIPDB?**
   The following are examples of law enforcement agencies that are eligible to access the HIPDB: the Office of Inspector General in the Department of Health and Human Services, the Department of Justice, the Federal Bureau of Investigation, the State Medicaid Fraud Control Units, the State Attorneys General, the District Attorneys, and the State law enforcement agencies that are involved in health care investigations. In addition, other Federal Inspectors' General and other Federal law enforcement agencies that are involved in health care investigations are eligible to access the HIPDB.

9. **Are hospitals eligible to access the HIPDB?**
   Section 1128E does not allow hospitals to query or report to the HIPDB unless the hospital meets the definition of a health plan or Federal or State agency.

Overview

The HIPDB collects and maintains information regarding final adverse actions taken against health care practitioners, providers, and suppliers. HIPDB information is intended to be used to help combat health care fraud and abuse, and to improve the quality of patient care. Examples of the types of actions in which HIPDB information should be used in combination with information from other sources include, but are not limited to: affiliation, certification, credentialing, contracting, hiring, and licensure.

Definitions

Since there is considerable overlap in the roles of practitioners, providers, and suppliers (e.g., a skilled nursing facility is an institutional provider, but also can be a supplier of health care items and equipment), the terms "practitioner," "provider," and "supplier" are not intended to describe distinct, mutually exclusive categories, nor are the examples provided intended to be exhaustive.

Licensed Health Care Practitioner, Licensed Practitioner, and Practitioner

An individual who is licensed or otherwise authorized by the State to provide health care services; or any individual who, without authority, holds himself or herself out to be so licensed or authorized.

Health Care Provider

- A provider of services as defined in Section 1861(u) of the Social Security Act .
- Any health care entity that provides health care services and follows a formal peer review process for the purpose of furthering quality health care (including an HMO, PPO, or group medical practice).
- Any other health care entity that, directly or through contracts, provides health care services.

Health Care Supplier

A provider of medical or other health care services as described in Section 1861(s) of the *Social Security Act*; or any individual or entity who furnishes, whether directly or indirectly, or provides access to, health care services, supplies, items, or ancillary services (including, but not limited to, durable medical equipment suppliers; manufacturers of health care items; pharmaceutical suppliers and manufacturers; health record services such as medical, dental and patient records; health data suppliers; and billing and transportation service suppliers). The term also includes any individual or entity under contract to provide such supplies, items, or ancillary services; health plans as defined in 45 CFR 61.3 (including employers that are self-insured); and health insurance producers (including but not limited to agents, brokers, solicitors, consultants, and reinsurance intermediaries).

Examples of Practitioners (Include, but are not limited to):

Chiropractor

Counselor
Counselor, Mental Health
Professional Counselor
Professional Counselor, Alcohol
Professional Counselor, Family/Marriage
Professional Counselor, Substance Abuse

Dental Service Provider
Dentist
Dental Resident
Dental Assistant
Dental Hygienist
Denturist

Dietician/Nutritionist
Dietician
Nutritionist

Emergency Medical Technician (EMT)
EMT, Basic
EMT, Cardiac/Critical Care
EMT, Intermediate EMT, Paramedic

Nurse/Advanced Practice Nurse
Registered (Professional) Nurse
Nurse Anesthetist
Nurse Midwife
Nurse Practitioner
Licensed Practical or Vocational Nurse

Nurses Aide/Home Health Aide
Nurses Aide
Home Health Aide (Homemaker)

Eye and Vision Service Provider
Ocularist
Optician
Optometrist

Pharmacy Service Provider
Pharmacist
Pharmacist, Nuclear
Pharmacy Assistant

Physician
Allopathic Physician (MD)
Allopathic Physician Intern/Resident
Osteopathic Physician (DO)
Osteopathic Physician Intern/Resident

Physician Assistant
Physician Assistant, Allopathic
Physician Assistant, Osteopathic

Podiatric Service Provider
Podiatrist
Podiatric Assistant

Psychologist, Clinical

Rehabilitative, Respiratory, and Restorative Service Provider
Art/Recreation Therapist
Massage Therapist
Occupational Therapist
Occupational Therapy Assistant
Physical Therapist
Physical Therapy Assistant
Rehabilitation Therapist
Respiratory Therapist
Respiratory Therapy Technician

Social Worker

Speech, Language, and Hearing Service Provider
Audiologist
Speech/Language Pathologist

Technologist
Medical Technologist
Cytotechnologist
Nuclear Medicine Technologist
Radiation Therapy Technologist
Radiologic Technologist

Other Health Care Practitioner
Acupuncturist
Athletic Trainer
Homeopath
Medical Assistant
Midwife, Lay (Non-nurse)
Naturopath
Orthotics/Prosthetics Fitter
Perfusionist
Psychiatric Technician

Examples of Health Care Providers and Suppliers (Include, but are not limited to):

Individuals

Health Care Facility Administrator
Adult Care Facility Administrator
Hospital Administrator
Long-Term Care Administrator

Health Insurance Provider/Supplier
Insurance Agent
Insurance Broker

Organizations

Ambulance Service/Transportation Company

Group or Practice
Chiropractic Group Practice
Dental Group Practice
Medical Group Practice
Mental Health/Substance Abuse Group Practice
Optician, Optometric Group Practice
Physical/Occupational Therapy Group Practice
Podiatric Group Practice

Health Care Supplier/Manufacturer
Biological Products Manufacturer
Blood Bank
Durable Medical Equipment Supplier
Fiscal/Billing/Management Agent
Nursing/Health Care Staffing Service
Organ Procurement Organization
Eyewear Equipment Supplier
Pharmacy
Pharmaceutical Manufacturer
Portable X-Ray Supplier
Purchasing Service

Health Insurance Company

Home Health Agency/Organization

Hospice/Hospice Care Provider

Hospital
General/Acute Care Hospital
Psychiatric Hospital
Rehabilitation Hospital
Federal Hospital

Other Health Care-Related Occupation
Accountant
Bookkeeper
Business Manager
Business Owner
Corporate Officer
Researcher, Clinical
Salesperson

Hospital Unit
Psychiatric Unit
Rehabilitation Unit

Laboratory/CLIA Laboratory

Nursing Facility/Skilled Nursing Facility

Research Center/Facility

Other Health Care Facility
Adult Day Care Facility
Ambulatory Surgical Center
Ambulatory Clinic/Center
End Stage Renal Disease Facility
Health Center-Federally Qualified Health Center/Community Health Center
Intermediate Care Facility for Mentally Retarded/Substance Abuse
Mammography Service Provider
Mental Health Center/Community Mental Health Center
Outpatient Rehabilitation Facility/Comprehensive Outpatient Rehabilitation Facility
Radiology: Imaging Center
Residential Treatment Facility: Program
Rural Health Clinic

Managed Care Organization
Health Maintenance Organization
Preferred Provider Organization
Provider Sponsored Organization
Religious-Fraternal Benefit Society Plan

Practitioner, Provider, and Supplier Self-Queries

Practitioners, providers, and suppliers may query the HIPDB regarding themselves (self-query) at any time. A practitioner, provider, or supplier may initiate a self-query by completing, printing, and returning the self-query form found on the NPDB-HIPDB website to the following address:

NPDB-HIPDB
P.O. Box 10832
Chantilly, VA 20151

Additional information on the self-query process can be obtained on the NPDB-HIPDB website.

A practitioner, provider, or supplier who submits a self-query to the HIPDB will receive in response either a notification that no information exists in the HIPDB, or a copy of all report information submitted by eligible reporting entities about the practitioner, provider, or supplier.

Fees are charged for all self-queries to the HIPDB, and must be paid by credit card. Further details regarding the payment of self-query fees are found on the NPDB-HIPDB website.

Practitioner, Provider, or Supplier Information in the HIPDB

The HIPDB is committed to maintaining accurate information and ensuring that health care practitioners, providers, and suppliers are informed when adverse actions are reported. When the HIPDB receives a report, the information is processed by the HIPDB computer system exactly as submitted by the reporting entity. Reporting entities are responsible for the accuracy of the information they report to the HIPDB.

When the HIPDB processes a report, a *Report Verification Document* is sent to the reporting entity, and a *Notification of a Report in the Data Bank(s)* is sent to the subject. The practitioner, provider, or supplier who is the subject of the report should review the report for accuracy, including such information as current address, telephone number, and place of employment. **Subjects may not submit changes to reports.** If any information in a report is inaccurate, the subject must contact the reporting entity to request that it file a correction to the report. The HIPDB is prohibited by law from modifying information submitted in reports.

If the reporting entity refuses to correct the *Adverse Action Report* or the *Judgment or Conviction Report*, the subject of the report may:

- Add a statement to the report.
- Initiate a dispute of the report.
- Add a statement and initiate a dispute.

For further details regarding the HIPDB dispute process, refer to the Disputes section of this *Guidebook*.

Questions and Answers

1. **How do I correct my address if it is wrong in a report?**

   Because neither the HIPDB nor a subject of a report may modify information contained in a report, you must contact the reporting entity (identified in the *Notification of a Report in the Data Bank(s)* document) and request that it correct the address on the report. If the reporting entity does not honor your request to correct the inaccurate address, you may dispute the report. Refer to the Disputes section of this *Guidebook* for more information about the HIPDB dispute process.

2. **Can a health plan or a State Licensing Board require that I give them the results of my self-query?**

   The response you receive to a self-query is yours to do with as you wish. Various licensing, credentialing, and insuring organizations may require a copy of your self-query response before you may participate in their program. Any arrangement between you and one of these organizations is voluntary; HHS does not regulate such arrangements.

3. **The reporter has denied your request to correct the report. The regulations say that only the reporter can make changes to the report. What can the subject do?**

   You may add a 2,000-character statement to the report, stating what you believe occurred. Also, if you believe the reporter does not meet the appropriate criteria to even submit a report, or if there are factual inaccuracies in the report, you may initiate a dispute of the report. Refer to the Disputes section of this *Guidebook* for more information about the HIPDB dispute process.

Overview

The HIPDB is a resource to assist health plans and Federal and State Government agencies to conduct law enforcement investigations and reviews of the qualifications of health care practitioners, providers, and suppliers. The primary goals of the HIPDB are to help prevent fraud and abuse in the national health care system and to improve the quality of patient care. In addition, queriers may use HIPDB information in making decisions regarding affiliation, verification, contracting, credentialing, employment, and licensure of practitioners, providers, and suppliers.

The HIPDB collects and disseminates to eligible queriers information on:

- Health care-related civil judgments taken in Federal or State court.
- Health care-related criminal convictions taken in Federal or State court.
- Injunctions.
- Federal or State licensing and certification actions, including revocations; reprimands; censures; probations; suspensions; and any other loss of license, or the right to apply for or renew a license, whether by voluntary surrender, non-renewability, or otherwise.
- Exclusions from participation in Federal and State health care programs.
- Any other adjudicated actions or decisions defined by regulation (see the Reports chapter of this *Guidebook*).

HIPDB information is available, upon request, to:

- Federal and State Government agencies.
- Health plans.
- Health care practitioners, providers, and suppliers requesting information concerning themselves (self-query).
- Persons or organizations requesting information in a form which does not permit the identification of any particular patient or health care practitioner, provider, or supplier.

The limited access provisions of the Section 1128E do not allow the disclosure of HIPDB information to the general public.

The HIPDB system will not allow entities to submit queries which do not include information in all mandatory fields. The HIPDB suggests that entities include, as part of the application process, information needed to complete mandatory fields for HIPDB queries.

Types of Queriers

Federal and State Government Agencies

Criminal justice authorities, government investigators, and prosecutors may query the HIPDB to further investigations on health care practitioners, providers, and suppliers. Federal and State prosecutors (e.g., Federal Bureau of Investigation, U.S. Attorney) may also use HIPDB information in making decisions to accept plea agreements or in making sentencing recommendations to the court.

Other governmental organizations may query the HIPDB with respect to credentialing, licensing, or certification of health care practitioners, providers, and suppliers. Some components in this group administer or provide payment for health care items or services, while others audit, evaluate, and review program operations to ensure effectiveness and efficiency. Those organizations responsible for licensing and certification functions may choose to query the database to confirm or collect information during the review of initial or renewal applications. Similarly, other Federal or State agency users (e.g., State Medical Board, Food and Drug Administration) may choose to query the HIPDB to determine a practitioner's, provider's, or supplier's eligibility for participation, or to ensure that subjects have been reported properly.

Health Plans

Health plans may have a variety of reasons for querying the HIPDB, principally in relation to credentialing or contracting with practitioners, providers, and suppliers. Health plans may query on specific subjects who have applied or are being considered for association with the plan.

Health plans also may query the HIPDB to detect and investigate potential fraudulent and abusive activity related to the payment or delivery of health care services. Typically, health plan units develop cases for presentation to Government investigators and prosecutors, who, in turn, take the information and move toward criminal, civil, or administrative actions. HIPDB information may also be used by the health plan's parent organization to pursue civil actions against a specific practitioner, provider, or supplier.

Practitioners, Providers, and Suppliers

Practitioners, providers, and suppliers may request information about themselves (self-query) from the HIPDB at any time, for any purpose.

Submitting a Query to the HIPDB

Eligible entities prepare and submit queries using the NPDB-HIPDB's Integrated Querying and Reporting Service (IQRS). Entities may submit single-name or multiple-name (batch) queries electronically to the HIPDB via modem through the Internet. When the HIPDB processes query data submitted via the IQRS, the query response is stored for the querying entity to retrieve through the IQRS.

Equipment Needed to Query Electronically

Eligible entities that wish to query must have Internet access and an Internet browser: either Microsoft Internet Explorer Version 4.01 Service Pack 2 (or higher) or Netscape Communicator Version 4.08 (or higher). In addition, a plug-in or stand-alone program that can read files in Portable Document Format (PDF), such as Adobe Acrobat Reader 4.0, is required. A printer is required to print responses to queries and reports.

Querying Through an Authorized Agent

The HIPDB's response to a query submitted by an Authorized Agent on behalf of an entity will be based upon two eligibility standards: (1) the entity must be entitled to receive the information, and (2) the Agent must be authorized to receive that information on behalf of that entity.

Before an Authorized Agent submits a query on behalf of an entity, the entity must indicate to the HIPDB whether the query responses are to be returned either to the entity or to the Agent; responses may not be returned to both. **The entity must have the capability to receive the response through the IQRS if the response is to be routed back to the entity.**

Authorized Agents must understand that they cannot use a query response for a particular practitioner, provider, or supplier on behalf of more than one entity. The HIPDB regulations specify that information received from the HIPDB must be used solely for the purpose for which it was provided. Therefore, an Authorized Agent that queries on a particular practitioner, provider, or supplier on behalf of one health plan may not use the query response for that practitioner, provider, or supplier for a different health plan.

An eligible querier that has designated an Authorized Agent is also permitted to query the HIPDB directly. Responses to queries submitted by the entity will be returned to the entity, regardless of routing designated for queries submitted by the Agent.

Lost Your HIPDB Password?

If you have already registered for the HIPDB and cannot locate your password, call the NPDB-HIPDB

Help Line for assistance. The Help Line will assist you in obtaining a new password for your organization.

Query Processing

When the HIPDB receives a properly completed query, the information is entered into the HIPDB computer system. The computer system performs a validation process that matches subject (i.e., practitioner, provider, or supplier) identifying information submitted in the query with information previously reported to the HIPDB. Information reported about a specific practitioner is released to an eligible querier only if the identifying information provided in the query matches the information in a report.

Each query processed by the HIPDB computer system is assigned a unique Document Control Number (DCN). This Document Control Number is used by the HIPDB to locate the query within the computer system. The DCN is prominently displayed in a query response. If a question arises concerning a particular query, the entity must reference the DCN in any correspondence to the HIPDB.

Character Limits

Each field in a query (such as Name, Work Address, and License Number) is limited to a certain number of characters, including spaces and punctuation. The IQRS will not allow the entity to use more than the allotted number of characters. **The HIPDB will not change any information submitted in a query.**

Query Responses

Each time a query is successfully processed by the HIPDB computer system, a query response is stored for the querying entity to retrieve through the IQRS. Practitioners, providers, and suppliers who self-query will receive paper responses sent by First Class U.S. mail.

When there is no information in the HIPDB about a subject practitioner, provider, or supplier, the querier will receive in response only the subject identifying information provided in the query and a notification that no information about the subject practitioner, provider, or supplier is contained in the HIPDB. Query information is not retained on subjects for whom no adverse actions have been reported.

Query Response Times

A query on one practitioner, provider, or supplier is considered a single-name query; a query on more than one practitioner, provider, or supplier is considered a multiple-name query. Each single-name query is assigned a unique DCN. A multiple-name query is assigned a Batch DCN, and each name within the query is assigned an individual DCN.

All queries submitted electronically via the IQRS are normally processed within four to six hours of receipt. However, during periods of high volume, the processing time may be longer.

Ideally, information from the HIPDB will be considered during the credentialing process. However, the HIPDB law does not require querying entities to receive query responses from the HIPDB before proceeding with hiring or the issuance of licenses. Because the HIPDB is one of several resources for the credentials review process, entities may act on applications according to their established criteria and information obtained from other sources.

Missing Query Responses

If you submit a query to the HIPDB via the IQRS and have not received a response within one week, call the NPDB-HIPDB Help Line to request a query status.

Correcting Query Information

If the information you submitted in a query does not accurately identify the practitioner, provider, or supplier on whom you intended to query, your query will not match HIPDB reports submitted with correct identifying information. To query the HIPDB with the proper identifying information on the subject, submit a new, correctly completed query to the HIPDB.

Failure to Query

Querying the HIPDB is optional. There are no mandatory querying requirements placed on eligible queriers.

Questions and Answers

1. **When I register with the HIPDB, am I automatically registered to use the IQRS?**

   Yes. Your organization's DBID and password for the IQRS are included on the *Entity Registration*

Verification document mailed to your organization at the time your entity is registered with the HIPDB. If you lose your DBID or password, contact the NPDB-HIPDB Help Line.

2. **Can I submit queries to the HIPDB on diskette, as I did for the NPDB?**

   No. All queries submitted to the HIPDB must be submitted electronically, via the IQRS.

3. **If I cannot find, or did not receive, a response to a query, may I request a copy from the HIPDB?**

   No. The HIPDB currently does not have the capability to produce duplicate responses. If you did not receive a response to a query and were not charged for the query, the query has not been processed by the HIPDB and should be resubmitted. Once processed by the HIPDB, query responses will be maintained on the IQRS for 30 days. After 30 days, the responses will be deleted from the IQRS, and the entity will have to resubmit the query to receive a response.

4. **Can I designate more than one Authorized Agent to query for my entity?**

   Yes. The HIPDB computer system can accommodate multiple Authorized Agents for each querying entity.

5. **If I decide to designate an Authorized Agent, or to change from one Agent to another, how long will it take before the Authorized Agent can query for my organization?**

   If the Agent is already registered with the HIPDB and has been assigned a DBID, the HIPDB will send notification documents to your organization. You should check the document to ensure that all information is correct. Your Authorized Agent will be able to query on your organization's behalf immediately upon your receipt of the notification documents.

   If the Agent is not already registered with the HIPDB, the Agent must call the NPDB-HIPDB Help Line to obtain an *Authorized Agent Registration* form. Once the Agent is registered, a DBID and password will be assigned to that Agent, and the entity can designate that Agent to report and/or query on its behalf.

Overview

The HIPDB acts as a flagging system; its principal goal is to prevent health care fraud and abuse and to improve the quality of patient care within the United States. Information on final adverse actions is collected from and disseminated to eligible entities. The HIPDB information should be considered with other relevant information in law enforcement investigations and evaluating the credentials of a practitioner, provider, or supplier.

Health plans and Federal and State Government agencies are responsible for reporting to the HIPDB final adverse actions taken against health care practitioners, providers, and suppliers. Final adverse actions include:

- Health care-related civil judgments entered in Federal or State court.
- Health care-related criminal convictions entered in Federal or State court.
- Federal or State licensing and certification actions.
- Exclusion from participation in Federal or State health care programs.
- Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

Settlements in which no findings or admissions of liability have been made are statutorily excluded from being reported. Additionally, actions with respect to medical malpractice claims are not reportable under the HIPDB's enabling statute.

All reports must be submitted electronically to the HIPDB. Reports may be submitted via the Internet using the NPDB-HIPDB Integrated Querying and Reporting Service (IQRS) at www.npdb-hipdb.com, or on diskette in a format specified by the HIPDB. The Interface Control Document (ICD), which specifies the format for diskette submission is available on the NPDB-HIPDB website.

Official Language

The official language of the HIPDB is English. All documents submitted to the HIPDB must be written in English. Documents submitted in any other language will not be accepted.

Computation of Time Periods

Health plans and Federal and State Government agencies must report final adverse actions to the HIPDB within 30 calendar days of the date the action was taken or the date when the reporting entity became

aware of the final adverse action, or by the close of the entity's next monthly reporting cycle, whichever is later.

In computing the time period for reporting to the HIPDB, the date of the act or event in question shall not be included. Saturdays, Sundays, and Federal holidays are to be included in the calculation of time periods. If the end date for submitting a report falls on a Saturday, Sunday, or Federal holiday, the due date is the next Federal work day. This method of computation of time periods is consistent with the *Federal Rule of Civil Procedure #6*.

The information required to be reported to the HIPDB is applicable to all health care practitioners, providers, and suppliers.

The HIPDB system does not accept reports that do not include information in all mandatory fields. An entity's lack of mandatory information does not relieve it of its reporting requirements for the purposes of Section 1128E. The HIPDB suggests that entities obtain the information needed to complete mandatory fields for the HIPDB reports as part of their application process.

Time frame for Reporting Final Adverse Actions

Mandated HIPDB reporters must report all final adverse actions taken on or after August 21, 1996. This is the date of passage of the HIPDB legislation. The HIPDB cannot accept any report with a date of action taken prior to August 21, 1996.

Civil Liability Protection

The immunity provisions in Section 1128E protects individuals, entities, and their authorized agents from being held liable in civil actions for reports made to the HIPDB unless they have actual knowledge of falsity of the information. The statute provides the same immunity to DHHS in maintaining the HIPDB.

Types of Reports

Initial Report

The first record of an adverse action submitted to, and processed by, the HIPDB is considered the Initial Report. An Initial Report remains the current version of the report until a Revision to Action or a Correction or Void is submitted.

When the HIPDB processes an Initial Report submitted via the IQRS, a *Report Verification* document is stored for the reporting entity to retrieve through the IQRS. When an Initial Report is submitted on

diskette, the *Report Verification* document is sent to the reporting entity via the U.S. Postal Service. Additionally, a *Notification of a Report in the Data Bank(s)* is mailed to the subject of the report. The reporting entity and the subject of the report should review the information to ensure that it is correct.

Correction

A Correction is a change intended to supersede the contents of the current version of a report. The reporting entity must submit a Correction as soon as possible after the discovery of an error or omission in a report. A Correction may be submitted to replace the current version of a report as often as necessary.

When the HIPDB processes a Correction submitted via the IQRS, a *Report Verification* document is stored for the reporting entity to retrieve through the IQRS. When a Correction is submitted on diskette, the *Report Verification* document is sent to the reporting entity via the U.S. Postal Service. Additionally, a *Report Revised, Voided, or Status Changed* document is mailed to the subject of the report and to all queriers who received the previous version of the report within the past 3 years. The reporting entity and the subject of the report should review the information to ensure that it is correct, and queriers should note the changed report.

Void Previous Report

A Void is the retraction of a report in its entirety. The report is removed from the subject's disclosable record. A Void may be submitted by the reporting entity at any time.

When the HIPDB processes a Void submitted via the IQRS, a *Report Verification* document is stored for the reporting entity to retrieve through the IQRS. When a Void is submitted on diskette, the *Report Verification* document is sent to the reporting entity via the U.S. Postal Service. Additionally, a *Report Revised, Voided, or Status Changed* document is mailed to the subject of the report and to all queriers who received the previous version of the report within the past 3 years. The reporting entity and the subject of the report should review the information to ensure that the correct report was voided, and queriers should note the void of the report.

Revision to Action

A Revision to Action is a new report denoting an action that relates to and modifies an adverse action previously reported to the HIPDB. The entity that reports an initial adverse action must also report any revision to that action.

Examples of Revisions to Action include the reinstatement of a license, the extension of an exclusion from a Government program, or the overturning of a judicial action. **A Revision to Action should not be reported unless the initial action was reported to the HIPDB.**

A Revision to Action is separate and distinct from a Correction. For example, if a reporting entity enters a Date of Action incorrectly, a Correction must be submitted to make the necessary change, and the Correction overwrites the previous version of the report. A Revision to Action is treated as an addendum to the previous report, but is filed as a separate, distinct action.

Example: A State licensing board submits an initial *Adverse Action Report* when it suspends a nurse practitioner's license for a period of 90 days. The suspension is later reduced to 45 days. Since this is a new action that modifies a previously reported action, the State licensing board must submit a new report using the Revision to Action option. The Initial Report documents that the State licensing board suspended the practitioner's license, and the Revision to Action documents that the State licensing board made a revision to the previous action.

When the HIPDB processes a Revision to Action submitted via the IQRS, a *Report Verification* document is stored for the reporting entity to retrieve through the IQRS. When a Revision to Action is submitted on diskette, the *Report Verification* document is sent to the reporting entity via the U.S. Postal Service. Additionally, a *Notification of a Report in the Data Bank(s)* is mailed to the subject of the report. The reporting entity and the subject of the report should review the information to ensure that it is correct.

Notice of Appeal

A Notice of Appeal is a report notifying the HIPDB that a subject has formally appealed a previously reported adverse action. A Notice of Appeal is separate and distinct from a subject's dispute of a HIPDB report. For more information regarding the HIPDB dispute process, refer to the Disputes section of this *Guidebook*.

When the HIPDB processes a Notice of Appeal submitted via the IQRS, a *Report Verification* document is stored for the reporting entity to retrieve through the IQRS. When a Notice of Appeal is submitted on diskette, the *Report Verification* document is sent to the reporting entity via the U.S. Postal Service. Additionally, a *Report Revised, Voided, or Status Changed* document is mailed to the subject of the report and to all queriers who received the previous version of the report within the past 3 years. The reporting entity and the subject of the report should review the information to ensure that it is correct, and queriers should note that the action upon which the report is based has been appealed.

Report Processing

Each version of a report processed by the HIPDB computer system is assigned a unique Document Control Number (DCN). This number is used to locate the report within the HIPDB system. The DCN is prominently displayed on all report documents. The DCN assigned to the most current version of the report must always be referenced in any subsequent action involving the report. For example, if an entity

wishes to correct an Initial Report it submitted, the entity must provide the DCN of that report when submitting the Correction to the HIPDB.

Report Responses

HIPDB responses to reports submitted via the IQRS are normally processed within four to six hours. HIPDB responses to reports submitted on diskette are sent to the reporting entity via the U.S. Postal Service within 10 business days of receipt.

Missing Report Verification

If you submit a report to the HIPDB and it is not available for retrieval from the IQRS within 5 business days, or if you submit a report on diskette and do not receive a response within 20 business days, call the NPDB-HIPDB Help Line to request a report status.

Reporting Judgments or Convictions

Health care-related judgments and convictions that must be reported to the HIPDB include: criminal convictions, civil judgments, injunctions, and *nolo contendere*/no contest pleas related to health care.

Federal or State Health-Care-Related Criminal Convictions

Federal, State, and local prosecutors must report criminal convictions against health care practitioners, providers, and suppliers related to the delivery of health care items or services. Section 1128E defines a criminal conviction as described in Section 1128(I) of the *Social Security Act*.

For the purposes of the HIPDB, a criminal conviction includes those cases:

- When a judgment or conviction has been entered against the individual or entity in a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment or conviction or other record relating to criminal conduct has been expunged.
- When there has been a finding of guilt against the individual or entity in a Federal, State, or local court.
- When a plea of guilty or nolo contendere by the individual or entity has been accepted by a Federal, State, or local court.
- When the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment or conviction has been withheld.

Examples of Reportable Criminal Convictions

(The following are actual descriptions of criminal convictions)

- A mental health institution is convicted of condoning physically abusive methods in controlling their patients and is sentenced to a large fine.
- The Chief Executive Officer of a health plan, a licensed physician, is convicted of embezzlement from the health plan and is sentenced to 4 years in prison.
- A chiropractor accepts kickbacks from a medical supply company in exchange for patient referrals. Both the chiropractor and the medical supply company are convicted, and each is sentenced to a $20,000 fine.
- A practitioner accepts small sums of money for referral to a specialist. The offense results in a deferred conviction in which he must satisfy a 2-year probationary period before the conviction is dropped.
- A Durable Medical Equipment (DME) company is sentenced as a result of pleading guilty to receiving an illegal kickback of $489,000. The DME company received the kickback payment as inducement to permit another DME supplier to provide incontinence kits to Medicare beneficiaries. These beneficiaries lived in a chain of nursing homes owned by the same management as the DME company. As a result of the kickback payment, Medicare paid approximately $3.6 million for incontinence supplies which were not medically necessary. The court ordered that the company pay a fine of $293,400 and that the defendant corporation be placed on probation for 2 years. During that period, the company was directed to implement and submit to the court a corporate compliance program, including a schedule for implementation.
- Two owners/operators of two separate ambulance companies were sentenced for their part in a Medicaid fraud scheme. Each was sentenced to 12 months and one day incarceration to be followed by 3 years supervised probation, and ordered to pay $2,000 in restitution. The owners purchased Medicaid information, which identified recipients who had been transported to the hospital by car or by public transportation, from an individual who worked at a local hospital. The owners used the information to create false claims, then billed Medicaid for ambulance services which were never provided. They received more than $120,000 as a result of the false claims.
- A man was sentenced for conspiracy to submit false Medicare claims in connection with his two durable medical equipment (DME) companies and his medical diagnostic company. His sentence included 21 months incarceration, payment of $1 million in restitution (offset by any money the Government recovers from the sale of his house) and 3 years supervised release. From 1992 to

1996, the company owner paid patient recruiters to bring Medicare beneficiaries to certain licensed physicians whom he paid to order DME and diagnostic testing. Through his companies, he then submitted Medicare claims for DME and oximetry tests that were not ordered or were not medically necessary.

- Two former owners of a home health agency (HHA) were sentenced for participating in a scheme to defraud Medicare. The co-owners included $296,000 in expenses not related to patient care in their cost reports. These expenses were fictitiously claimed as consulting and salary payments to family and friends. One of the HHA owners was sentenced to 8 months incarceration followed by 2 months in a halfway house as part of a 2-year supervised release program. The other was sentenced to 5 months imprisonment and 3 years supervised probation. The owners were also ordered to pay restitution totaling $244,472.

Examples of Non-Reportable Criminal Convictions

- A civil judgment against a physician is reached for medical malpractice and the jury awards $15,000 to the plaintiff.
- A practitioner is found to be addicted to a drug, and instead of being convicted for possession and abuse, the practitioner is given a deferred conviction and is sent to a rehabilitation facility.

Injunctions

Federal and State prosecutors and investigative agencies must report injunctions against health care practitioners, providers, and suppliers. The injunction must be related to the delivery of a health care item or service to be reportable.

Example of a Reportable Injunction

A pharmaceutical company distributes a drug that produces harmful side effects in rare cases, and the FDA imposes an injunction to stop the production of the drug.

Example of a Non-Reportable Injunction

A practitioner has an injunction imposed against him by his wife, whom he has been harassing.

Nolo Contendere/No Contest Plea

Federal and State prosecutors and investigative agencies must report *nolo contendere*/no contest pleas by health care practitioners, providers, and suppliers. A plea of *nolo contendere* has the same effect as

a plea of guilty as far as the criminal sentence is concerned, but may not be considered as an admission of guilt for any other purpose. The *nolo contendere*/no contest plea must be related to the delivery of a health care item or service to be reportable.

Example of a Reportable Nolo Contendere/No Contest Plea

A practitioner pleads *nolo contendere* to insurance fraud related to health care.

Example of a Non-Reportable Nolo Contendere/No Contest Plea

A provider pleads *nolo contendere* to insurance fraud not related to health care.

Health Care-Related Civil Judgments

Federal and State attorneys and health plans must report civil judgments against health care practitioners, providers, or suppliers related to the delivery of a health care item or service, regardless of whether the civil judgment is the subject of a pending appeal. If a Government agency is party to a multi-claimant civil judgment, it must assume the responsibility for reporting the entire action, including all amounts awarded to all the claimants, both public and private. When a government agency is not a party, but there are multiple health plans as claimants, the health plan which receives the largest award is responsible for reporting the total action for all parties.

Examples of Reportable Civil Judgments

- A judgment is made against a clinical laboratory, resulting in a $10,000 award for fraudulent billing and misleading marketing in a suit brought by health insurers and health care payers.
- A judgment against a nursing home imposes a $50,000 fine for neglect and for failure to adequately clean the patients' rooms.
- A judgment against an ambulance transportation company results in a $30,000 fine for filing false and fraudulent claims and receiving payment for ambulance transportation to destinations not permitted by law, not medically necessary, and for patients whose ambulatory state did not require such transportation.
- A health plan does not cover cosmetic procedures. A plastic surgeon misrepresents to health plan members that a certain type of cosmetic surgery is covered by health care insurance although it is not. The member has the cosmetic surgery. The surgeon sends in the claim to the health plan mischaracterizing the surgery as a non-cosmetic procedure and is paid by the health plan.

Subsequently, the health plan discovers the fraudulent claims and sues to recover the overpayment. A judgment is rendered awarding the health plan $300,000.

Examples of Non-Reportable Civil Judgments

- A judgment imposes a $40,000 fine on a medical supplies company for hiring discrimination.
- A judgment of $30,000 is rendered against a practitioner for medical malpractice.
- A settlement that is reached outside the court.
- A judgment against a practitioner stemming from an automobile accident not related to the delivery of a health care item or service.

Reporting Adverse Actions

Adverse actions that must be reported to the HIPDB include: licensure and certification actions, Government health care program certification actions, exclusions from Federal and State health care programs, health care related criminal convictions and civil judgments, and other adjudicated actions or decisions as established by regulation.

Adverse Licensure or Certification Actions

Federal and State licensing and certification agencies must report final adverse licensure actions taken against health care practitioners, providers, or suppliers. A reportable final adverse licensure action must be a formal or official action; it need not be specifically related to professional competence or conduct. Such actions include, but are not limited to:

- Formal or official actions, such as the revocation or suspension of a license or certification agreement or contract for participation in Federal or State health care programs (and the length of any such suspension), reprimand, censure, or probation.
- Any other loss of license, certification agreement, or contract for participation in Federal or State health care programs; or the right to apply for or renew a license or certification agreement or contract of the practitioner, provider, or supplier, whether by operation of law, voluntary surrender, non-renewal (excluding nonrenewals due to nonpayment of fees, retirement, or change to inactive status), or otherwise.
- Any other negative action or finding by a Federal or State agency that is publicly available information and is rendered by a licensing or certification authority, including, but not limited to, limitations on the scope of practice, liquidations, injunctions, and forfeitures. This also includes final adverse actions

rendered by a Federal or State licensing or certification authority, such as exclusions, revocations, or suspension of license or certification that occur in conjunction with settlements in which no finding of liability has been made (although such a settlement itself is not reportable under the statute). This definition excludes administrative fines or citations, corrective action plans and other personnel actions unless they are connected to the billing, provision or delivery of health care services and taken in conjunction with other licensure or certification actions such as revocation, suspension, censure, reprimand, probation, or surrender.

Federal and State adverse licensure actions are reported under the appropriate licensure category on the *Adverse Action Report*. Adverse actions taken with regard to a certification agreement or contract for participation in Federal or State health care programs are reported under the Government Administrative action category on the *Adverse Action Report*.

Examples of Reportable Actions

The following adverse licensure actions must be reported to the HIPDB:

- The denial of an application for licensure (initial or renewal).
- A licensure disciplinary action taken by a State Licensing agency based upon the practitioner's, provider's, or supplier's deliberate failure to report a licensure disciplinary action taken by another licensing agency, when a report of such action is requested on a licensure application.
- Voluntary surrender of a license.

Examples of Non-Reportable Actions

The following adverse licensure actions should *not* be reported to the HIPDB:

- A settlement agreement which imposes the monitoring of a practitioner, provider, or supplier for a specific period of time, unless such monitoring constitutes a restriction on the licensee, or is considered to be a reprimand.
- A licensure disciplinary action which is imposed with a "stay" pending completion of specific programs or actions.
- The voluntary relinquishment of a practitioner's license for personal reasons such as retirement or change to inactive status.
- Licensure actions taken against non-health care practitioners, providers, or suppliers.
- An initial application for licensure in which a physician has failed to pass the required licensure exam is not accepted by a State Medical Board. In this case, there is no formal or official action to deny the license, making the event non-reportable.

Exclusions from Participation in Federal/State Health Care Programs

Federal and State agencies must report health care practitioners, providers, or suppliers excluded from participating in Federal or State health care programs. The term "exclusion" means a temporary or permanent debarment of an individual or entity from participation in a Federal or State health-related program, in accordance with which items or services furnished by such person or entity will not be reimbursed under any Federal or State health-related program. Section 1128E limits the definition of Federal or State health care programs to those programs defined in Sections 1128B(f) and 1128(h), respectively, of the *Social Security Act*.

Exclusions from Federal or State health care programs are reported under the Exclusion or Debarment category on the *Adverse Action Report*.

Examples of a Reportable Exclusion

A practitioner is excluded from a State Medicaid program after pleading guilty to filing false claims.

A physician was indefinitely excluded from a State Medicaid program because her medical license was suspended in Texas. The doctor's license suspension was due to several complaints, including placing an epidural catheter in a patient's abdomen during child birth, instead of properly placing the catheter in the spinal canal.

Example of a Non-Reportable Exclusion

A practitioner is found guilty in a criminal proceeding of filing false claims to Medicare, but is not excluded from a Federal or State health care program. This would be reportable only as a health-care-related criminal conviction.

Other Adjudicated Actions or Decisions

Federal and State Government agencies and health plans must report adjudicated actions or decisions against health care practitioners, providers, and suppliers. The term "other adjudicated actions or decisions" means:

(1) formal or official final actions taken against a health care practitioner, provider, or supplier by a Federal or State Government agency or a health plan;
(2) which include the availability of a due process mechanism; and
(3) based on acts or omissions that affect or could affect the payment, provision, or delivery of a health care item or service.

A hallmark of any valid adjudicated action or decision is the availability of a due process mechanism. The fact that the subject elects not to use the due process mechanism provided by the authority bringing the action is immaterial, as long as such a process is available to the subject before the adjudicated action or decision is made final. In general, if an adjudicated action or decision follows an agency's established administrative procedures (which ensure that due process is available to the subject of the final adverse action), it would qualify as a reportable action under this definition. The definition specifically excludes clinical privileging actions taken by Federal or State Government agencies and similar paneling decisions made by health plans. For health plans that are not Government entities, an action taken following adequate notice and the opportunity for a hearing that meets the standards of due process set out in section 412(b) of the HCQIA (42 U.S.C. 11112(b)) also would qualify as a reportable action under this definition.

The termination by a health plan or Federal or State agency of a practitioner's contract to provide health care services is reportable to the HIPDB if it meets the definition of an "other adjudicated action."

Examples of Reportable Other Adjudicated Actions or Decisions

The following are reportable when they meet the criteria indicated above:

- A health plan has a preferred provider contract with a psychiatrist allowing the psychiatrist to be directly paid by the plan at negotiated rates for covered psychiatric services to be rendered to plan members. It is discovered that the psychiatrist is sexually abusing his patients. The health plan, prior to a criminal adjudication, seeks to have the psychiatrist removed as a contracted practitioner by terminating the psychiatrist's contract with the health plan. If the action against the psychiatrist results in the termination of the psychiatrist's contract, this would be reportable. In this case, the contract termination is reportable, not the health plan's revocation of the psychiatrist's clinical privileges.
- A health plan has a preferred provider contract with a surgeon allowing the surgeon to be directly paid by the plan at negotiated rates for covered surgical services to be rendered to plan members. Complaints are received by the plan regarding the poor quality of the surgeon's services and patient care. After having the opportunity to be heard regarding the allegations the plan terminates his practitioner contract based upon quality of services and poor patient care.
- A health plan personnel-related suspension without pay against a practitioner.
- A Federal or State Government Agency reduction in pay action against a practitioner.
- A personnel-related action such as reductions in grade for cause.
- A personnel-related action such as a termination.
- A Federal or State Government contract terminated for cause.

Examples of Non-reportable Other Adjudicated Actions or Decisions

- An overpayment determination against a practitioner made by a Federal or State Government health care program, its contractor, or a health plan.
- A denial of claim determination against a practitioner made by a Federal or State Government agency or a health plan.
- A revocation of a physician's clinical privileges by a health plan or Federal or State hospital.

Submitting Reports to the HIPDB

The IQRS is designed to capture all of the necessary information for the successful submission of *Adverse Action Reports* and *Judgment or Conviction Reports* to the HIPDB. It is important to remember that if a record is incomplete (i.e., information is missing in required fields), the IQRS does not allow a report to be submitted to the HIPDB until the missing information is added.

Character Limits

Each data field in the IQRS is limited to a certain number of characters, including spaces and punctuation. Data are processed by the HIPDB system exactly as they are submitted by the reporting entity; the HIPDB will not change any data in a report.

The narrative description field allows the reporting entity to enter up to 2,000 characters, including spaces and punctuation. Any characters over the 2,000-character limit will not be accepted by the IQRS.

Subject Information

All required data fields identifying the subject of the report must be completed before the report can be submitted. Reporters should provide as much information as possible about the subject practitioner, provider, or supplier, even in fields that are not required. The inclusion of this information helps to ensure the accurate identification of the subject of the report.

When Subject Information is Unknown

The HIPDB suggests that each reporting entity review the mandatory data fields for reporting practitioners, providers, and suppliers, and make an effort to collect this information for each possible subject BEFORE there is cause to file a report. A report cannot be filed if required information is missing.

Incorrectly Identified Subject

If an entity reports information on the wrong practitioner, provider, or supplier, the reporting entity must submit a Void of the incorrect report, then submit a new report for the correct subject.

Failure to Report

Federal and State Government Agencies

If HHS determines that a Government agency has substantially failed to report information in accordance with Section 1128E, the name of the entity will be published.

Health Plans

Any health plan that fails to report information on an adverse action required to be reported to the HIPDB will be subject to a civil money penalty of up to $25,000 for each such adverse action not reported.

Questions and Answers

1. **What information will my organization be required to report if we are a HIPDB mandated reporter?**

   This information can be found in the HIPDB regulations, and depends upon the type of final adverse actions your organization takes against health care practitioners, providers, and suppliers.

2. **When will my organization be required to start reporting if we are a HIPDB mandated reporter?**

   Mandated HIPDB reporters have an obligation to report all final adverse actions against health care practitioners, providers, and suppliers taken on or after August 21, 1996. This is the date the of

passage of the HIPDB legislation. *The HIPDB cannot accept reports of actions taken before August 21, 1996.*

3. **What is the penalty for failure to report an action to the HIPDB?**

   Health plans are subject to a fine of up to $25,000 for each failure to report. The Secretary shall provide for the publication of the names of the Government agencies that fail to report as required.

4. **Will HIPDB mandated reporters who also report to the NPDB have to report the same action separately to the two Data Banks?**

   No. The statute requires that the HIPDB be implemented in a manner that avoids the duplication of the reporting requirements established for the NPDB. Therefore, entities that must report actions to both the NPDB and HIPDB will submit each report once. The IQRS will then automatically route the reports to the appropriate Data Bank(s).

5. **How long are reports held in the HIPDB?**

   Information reported to the HIPDB is maintained permanently, unless it is corrected or voided from the system. A Correction or Void may be submitted only by the reporting entity or at the direction of the Secretary of HHS.

6. **Can my organization provide a copy of a HIPDB report to the subject practitioner, provider, or supplier?**

   The HIPDB appreciates entities that attempt to maintain an open exchange with subjects. However, if you provide a copy of the report to the subject, be sure to remove or obliterate your organization's Data Bank Identification Number (DBID). The DBID must remain confidential to the organization to which it is assigned.

7. **I'm trying to report a practitioner who did not attend a Professional School, but the *Professional School(s) Attended* and *Year(s) of Graduation* fields are mandatory. How should I complete these fields?**

   Place "None" in the *Professional School(s) Attended* field and place the year the individual was approved or first licensed in the field in the *Year(s) of Graduation* field.

Reporting Adverse Licensure Actions

8. **How should a State Board report an action with several levels or components, for instance, a six-month license suspension followed by a two-year probation?**

   The Board should report the code of the principal sanction or action and describe its full order, including lesser actions, in the narrative of the *Adverse Action Report*. An additional report is not necessary when the lesser sanction or action is implemented, since it was included in the description in the Initial Report.

9. **How should a State Licensing Board report actions when they are changed by court order?**

   The Board should report the initial adverse action as usual; the judicial decision is reported as a Revision to Action. For example, if a Board revoked a physician's license and a judicial appeal resulted in the court modifying the discipline to probation for one year, then the Board would be required to report both its initial revocation action and the court-ordered revision to a one-year

probation. When a court stays a Board's order, this action must also be reported as a Revision to Action.

10. **When reporting a reprimand by a State Licensing Board, what Length of Action should be entered on the report form?**

    The Indefinite selection (formerly code "99") should selected on the appropriate report screen in the IQRS for reprimands reported to the HIPDB.

Reporting Exclusions or Debarments

11. **After an exclusion period is over and the practitioner is reinstated, is the initial exclusion report voided?**

    No. The HIPDB retains reports of final adverse actions permanently, or until they are corrected or voided by the reporting entity or at the direction of the Secretary of HHS.

12. **Is there a minimum period of exclusion time for an exclusion to be reportable?**

    No. Any amount of exclusion time is reportable.

Reporting Criminal Convictions

13. **If an individual is convicted of a health care-related offense, does the 30 days to report begin when the individual is convicted or when the individual is sentenced?**

    The report must be submitted within 30 calendar days of the date that the subject is convicted.

14. **Is a deferred conviction still reportable when the probationary period of the deferred conviction is successfully completed?**

    Yes. When the reporting agency is aware of the deferred conviction, the report must be submitted within 30 calendar days or the end of the monthly reporting cycle, whichever is later. The report should be submitted before the probationary period is completed, and reporting is not dependent upon the successful completion of the probation.

Reporting Injunctions

15. **If an injunction is placed on a supplier, but the supplier plans to appeal the action, does the supplier still get reported?**

    Yes. If, after the appeal, the injunction is lifted, a Revision to Action must be filed.

Reporting Other Adjudicated Actions or Decisions

16. **My organization, an HMO, recently terminated a physician. It seems like this action is reportable to both the HIPDB and the NPDB. How do I report this action?**

    If the physician's termination was considered a professional review action that resulted in the revocation of the physician's clinical privileges, the action is reportable to the NPDB. If the physician's termination was considered an other adjudicated action and resulted in the termination of the physician's contract with the HMO to provide health care services, it is reportable to the HIPDB. If the HMO revokes the physician's clinical privileges and terminates his contract, the HMO

must report the adverse clinical privileges action to the NPDB and the contract termination to the HIPDB.

Reporting Nolo Contendere/No Contest Plea

17. Is a plea of "guilty" the same as a plea of "*nolo contendere*"?

Yes, as far as the reportability of the action is concerned, however a plea of *nolo contendere* may not be considered as an admission of guilt for any other purpose.

Reporting Civil Judgments

18. A practitioner is guilty of medical malpractice and settles with the plaintiff. Is this reportable?

No. The HIPDB does not collect information on medical malpractice payments. However, if the practitioner was subsequently debarred from a Federal or State health care program as a result of the medical malpractice, the debarment would be reportable to the HIPDB.

The Dispute Process

The HIPDB is committed to maintaining accurate information and ensuring that health care practitioners, providers, and suppliers are informed when adverse actions are reported. When the HIPDB receives a report, the information is processed by the HIPDB computer system exactly as submitted by the reporting entity. Reporting entities are responsible for the accuracy of the information they report to the HIPDB.

When the HIPDB processes a report, a *Report Verification Document* is provided to the reporting entity, and a *Notification of a Report in the Data Bank(s)* is sent to the subject. The subject should review the report for accuracy, including such information as current address, telephone number, and place of employment. **Subjects may not submit changes to reports.** If any information in a report is inaccurate, the subject must contact the reporting entity to request that it file a Correction to the report. The HIPDB is prohibited by law from modifying information submitted in reports.

If the reporting entity declines to change the report, the subject may initiate a dispute of the report through the HIPDB dispute process, add a statement to the report, or both. The dispute process is not an avenue to protest a judgment or to appeal the underlying reasons of an adverse action affecting the subject's license or inclusion in a Federal or State health care program. Neither the merits of a criminal or civil suit nor the appropriateness of, or basis for an adverse action may be disputed.

Subjects who wish to add a statement to and/or dispute the factual accuracy of a report should follow the instructions on the *Notification of a Report in the Data Bank(s)*. Subjects who do not have the original *Notification of a Report in the Data Bank(s)* may obtain a *Subject Statement and Dispute Initiation* form from the NPDB-HIPDB website.

Subject Statements

The subject of a report may add a statement to a report at any time. When the HIPDB processes a statement, notification of the statement is sent to all queriers who received the report within the past 3 years, and will be included with the report when it is released to future queriers.

Subject Statements are limited to 2,000 characters, including spaces and punctuation. **Subject Statements must not include any patient names.** Drafting a statement in accordance with the character limits ensures that the statement will contain the information a subject deems most important. All characters beyond 2,000 will not be accepted.

A Subject Statement is part of the specific report for which it is filed. If the report is changed by the reporting entity, the statement attached to the report also will be removed. If a statement is needed with

the new report, a new statement will have to be submitted to the HIPDB, referencing the Document Control Number (DCN) of the new report.

Subject Disputes

The subject of an *Adverse Action Report* or *Judgment or Conviction Report* contained in the HIPDB may dispute either the factual accuracy of a report or whether a report was submitted in accordance with the HIPDB's reporting requirements, including the eligibility of the entity to report the information to the HIPDB. A subject may *not* dispute a report in order to appeal the underlying reasons for an adverse action.

If a subject believes that information in a report is factually inaccurate (for instance, an incorrect adverse action code or judgment date) or should not have been reported (for instance, a suspension or criminal conviction not related to health care), the subject must attempt to resolve the disagreement directly with the reporting entity. **Changes to the report may be submitted only by the reporting entity.**

When the HIPDB processes a dispute, notification of the dispute is sent to all queriers who received the report within the past 3 years, and will be included with the report when it is released to future queriers.

A dispute is part of the specific report for which it is filed. If the report is changed by the reporting entity, the dispute notation attached to the report also will be removed. If the subject believes that the new version of the report is factually inaccurate, the subject must initiate a new dispute of the changed report.

Secretarial Review

If the reporting entity declines to change the disputed *Adverse Action Report* or *Judgment or Conviction Report* or takes no action, the subject may request that the Secretary of DHHS review the disputed report. The Secretary will review disputed reports only for accuracy of factual information and to ensure that the information was required to be reported.

The Secretary will not review:

- The merits of a civil judgment or criminal conviction.
- The appropriateness of, or basis for a health plan's adjudicated action or a Government agency's or State Licensing Board's adverse action.

To request the review of a disputed report by the Secretary, the subject must sign and return to the HIPDB the Secretarial Review request page attached to the *Report Revised, Voided, or Status Changed*

document related to the disputed report. Please note that the dispute and any accompanying documentation must be sent to the HIPDB, not directly to the Secretary.

The subject also must:

- State clearly and briefly in writing which facts are in dispute and what the subject believes are the facts.
- Submit documentation substantiating that the reporting entity's information is inaccurate. Documentation must directly relate to the facts in dispute and must substantially contribute to a determination of the factual accuracy of the report. Documentation may not exceed 10 pages, including attachments and exhibits.
- Submit proof that the subject attempted to resolve the disagreement with the reporting entity, but was unsuccessful. Proof may be a copy of the subject's correspondence to the reporting entity and the entity's response, if any.

The subject of the report should wait for 30 days from the date of initiating discussions with the reporting entity before requesting Secretarial Review of the disputed report, to allow the reporting entity time to respond to a dispute.

Pertinent Documentation

If the dispute relates to an *Adverse Action Report*, pertinent documentation might include a copy of:

- The findings of fact and recommendations of the health plan or State Licensing Board.
- The final report of the hearing panel or other appellate body upon which the description of the acts or omissions was based.

If the dispute relates to a *Judgment or Conviction Report*, pertinent documentation might include a copy of:

- The court judgment.
- The injunction document.

If necessary, the Secretary will ask the reporting entity to supply additional information confirming that the report was submitted in accordance with HIPDB regulations. Entities must respond to a request for more information from the Secretary within 15 days. After reviewing all documentation related to the dispute,

the Secretary will determine whether the information in the disputed report is accurate and should have been reported to the HIPDB.

Secretarial Review Results

When the HIPDB receives proper notice of a request for Secretarial Review, the materials will be forwarded to the Secretary of DHHS for review. There are three possible outcomes for Secretarial Review of a dispute:

- The Secretary concludes that the report is accurate.
- The Secretary concludes that the report is inaccurate.
- The Secretary concludes that the issues in dispute are outside the scope of Secretarial Review.

Report Accurate as Submitted

If the Secretary concludes that the information in the report is accurate, the Secretary will send an explanation of the decision to the subject practitioner, provider, or supplier. The subject may then submit, within 30 days, a statement that will be added to the report. The statement is limited to 2,000 characters, including spaces and punctuation, and will be entered into the HIPDB computer system exactly as submitted. The new Subject Statement will replace any statement the subject submitted previously.

The subject of the report, the reporting entity, and all queriers who received notice of the disputed report within the past 3 years will receive a *Report Revised, Voided, or Status Changed* document containing the Secretary's explanation and the subject's statement. Future queriers will receive the subject's statement with the report.

Report Inaccurate as Submitted

If the Secretary concludes that the report is inaccurate, the Secretary will direct the HIPDB to correct the information in the report. The subject of the report, the reporting entity, and all queriers who received notice of the disputed report within the past 3 years will receive a *Report Revised, Voided, or Status Changed* document informing them of the correction.

If the Secretary concludes that the report was submitted in error, the Secretary will direct that the report be voided from the HIPDB. The subject of the report, the reporting entity, and all queriers who received notice of the disputed report within the past 3 years will receive a *Report Revised, Voided, or Status Changed* document informing them that the report has been voided.

Dispute Outside the Scope of Secretarial Review

If the Secretary concludes that the issue in dispute is outside the scope of review, the Secretary will direct the HIPDB to add an entry to that effect to the report and to remove the dispute notation from the report. The subject may then submit, within 30 days, a statement that will be added to the report. The statement is limited to 2,000 characters, including spaces and punctuation, and will be entered into the HIPDB computer system exactly as submitted.

The subject of the report, the reporting entity, and all queriers who received notice of the disputed report within the past 3 years will receive a *Report Revised, Voided, or Status Changed* document informing them of the Secretary's decision.

Reconsideration of the Secretary's Decisions on Disputes

Although DHHS does not have a formal appeals process for reconsideration of the Secretary's decisions on disputes, DHHS will review such requests. The subject practitioner, provider, or supplier must submit a written request for reconsideration to the office that issued the Secretary's determination. The subject should be specific about any new information that was unavailable at the time of Secretarial Review and/or which issues the subject believes were not appropriately considered during the review process. The Secretary will either affirm the prior determination or issue a revised finding. DHHS will, however, give priority to initial requests for Secretarial Review.

Improper Requests for Secretarial Review

A request for Secretarial Review is considered improper when the report in question has not previously been disputed by the subject practitioner, provider, or supplier. Before requesting Secretarial Review, a subject must:

- First, attempt to resolve the disagreement with the reporting entity.
- Second, dispute the report according to the instructions provided on the Notification of a Report in *the Data Bank(s)* document.

If a subject submits an improper request for Secretarial Review, the HIPDB will notify the subject practitioner, provider, or supplier that resolution with the reporting entity must be attempted first.

Examples of Disputes

Due Process - Alleged Denial

Example: A practitioner alleged that a health plan denied him due process because the health plan ignored the testimony of medical experts or other witnesses called to prove various points the practitioner felt were important to the defense.

Outcome: The Secretary determined that the dispute request was outside the scope of review and made an entry to that effect in the report. The dispute notation was removed from the report.

Narrative Description - Inaccurate

Example: A supplier disputed a report of a licensure disciplinary action taken by a State licensing agency stating that the narrative regarding the act was inaccurate. The supplier requested that the description be changed to reflect the findings of the agency.

Outcome: The Secretary reviewed the narrative against the findings reported by the licensing agency and determined that the report would be accurate if the actual language from the agency's findings were used. The Secretary directed the HIPDB to change the narrative. The dispute notation was removed from the report.

Licensure- Voluntary Surrender

Example: A nurse disputed a report that she had surrendered her license. The nurse disputed the report on the basis that she had surrendered due to personal reasons, unrelated to her practice. The nurse stated that she surrendered her license because she was moving to another State.

Secretary's Response: The Secretary requested that the State licensing board submit contemporaneous documentation showing that the reasons for the surrender were not as a result of the nurse simply surrendering her license to move to another State. The State licensing submitted documentation which showed that the nurse was under investigation for patient abuse and had agreed to the surrender in lieu of further disciplinary action. The Secretary determined that the action was reportable and made an entry to that effect in the report. The dispute notation was removed from the report.

Criminal Conviction

Example: A provider disputed a report of a health care-related criminal conviction. The provider argued that he was never convicted of a crime. The provider argued he had pleaded *nolo contendere* to an allegation of submitting false claims to a health plan and this did not constitute a criminal conviction.

Secretary's Response: The Secretary ruled this was a reportable event based on the definition of criminal conviction as referenced in the HIPDB regulations. The definition of criminal conviction includes a *nolo contendere* plea as a criminal conviction. The dispute notation was removed from the report.

Questions and Answers

1. **I am the executor of my wife's estate. I received notification of a report about her in the HIPDB. Can I dispute the report?**

   Yes. To dispute a report on your wife's behalf, you must provide documentation that you have been appointed the executor or legal representative of her estate. Acceptable documentation can be a photocopy of her will or other legal documentation showing you as the executor/legal representative.

2. **When a subject attempts to resolve a disagreement with a reporting entity, must the dispute be resolved within a certain time frame?**

   No. A subject must inform the reporting entity, in writing, of the subject's disagreement with the report and the basis for that disagreement, but there is no requirement that the dispute must be resolved within a certain amount of time.

3. **If a subject wishes to dispute a report, does the subject have to submit a statement at the time of dispute?**

   No. The subject *may* provide a statement with the initiation of dispute, but is not required to do so. A Subject Statement may be submitted at any time.

4. **Must a subject initiate a dispute in order to add a statement to a report?**

   No. The subject of a report may add a statement to a report independently of the dispute process.

5. **If the Secretary rules a dispute to be beyond the scope of review and places a notation to this effect in the HIPDB, can a subject also add a statement?**

Yes. Subjects will be notified of this option by the Secretary. A Subject Statement added to the report after dispute resolution will replace any prior Subject Statement.

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NPDB Guidebook

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Preface

The *National Practitioner Data Bank Guidebook* is meant to serve as a resource for the users of the National Practitioner Data Bank (NPDB). It is one of a number of efforts to inform the United States health care community about the NPDB and what is required to comply with the requirements established by Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986*, as amended. This *Guidebook* contains information that authorized users need to interact with the NPDB. Authorized users include State licensing authorities; medical malpractice payers; hospitals and other health care entities; and physicians, dentists, and other licensed health care practitioners.

Final regulations governing the NPDB were published in the *Federal Register* on October 17, 1989, and are codified at 45 CFR Part 60. The U.S. Department of Health and Human Services (HHS) is responsible for implementing the NPDB.

This *Guidebook* is divided into broad topical sections. This introduction contains general information on the NPDB, which includes its history, the laws and regulations that govern it, and other information for authorized users. Chapter H, Information Sources, provides a variety of sources to facilitate user interaction with the NPDB. The Glossary, included as Appendix A, defines terms helpful in understanding NPDB operations, including querying and reporting requirements.

This edition of the *NPDB Guidebook* reflects the entire range of NPDB policies and operations, including those that have changed or expanded since the NPDB opened in September 1990. This comprehensive *Guidebook* is for both new and experienced entities that are eligible to participate in the NPDB; it supersedes all previous versions.

Background

The legislation that led to the creation of the NPDB was enacted because the U.S. Congress perceived that the increasing occurrence of medical malpractice litigation and the need to improve the quality of medical care had become nationwide problems that warranted greater efforts than those that could be undertaken by any individual State. Effective professional peer review can restrict the ability of incompetent practitioners to move from State to State without disclosure or discovery of previous damaging or incompetent performance. The Congress felt that the threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discouraged physicians and dentists from participating in effective professional peer review. Therefore, Congress sought to provide incentive and protection for physicians and dentists engaging in effective professional peer review.

Hearings were held in the U.S. House of Representatives on the proposed legislation, the *Health Care Quality Improvement Act of 1986*, on March 18 and July 15, 1986, by the Subcommittee on Health and the Environment, Committee on Energy and Commerce, and on October 8 and 9, 1986, by the Subcommittee on Civil and Constitutional Rights, Committee on the Judiciary. At these public hearings, testimony was given by physicians, attorneys, insurance

officials, representatives of health care associations, and others. The *Health Care Quality Improvement Act of 1986* was incorporated as Title IV into legislation requiring States to develop, establish, and implement State comprehensive mental health plans. This legislation became Public Law 99-660 when it was signed by President Ronald Reagan on November 14, 1986.

Title IV of Public Law 99-660

The intent of Title IV of Public Law 99-660 is to improve the quality of health care by encouraging State licensing boards, hospitals and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior; and to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice payment and adverse action history. Adverse actions can involve licensure, clinical privileges, and professional society memberships.

Civil Liability Protection

To encourage and support professional review activity of physicians and dentists, Part A of Title IV provides that the professional review bodies of hospitals and other health care entities, and persons serving on or otherwise assisting such bodies, are offered immunity from private damages in civil suits under Federal or State law. Immunity provisions apply when professional review responsibilities are conducted with the reasonable belief of furthering the quality of health care and with proper regard for due process. There are exceptions under the law for civil rights actions and antitrust actions brought by Federal and State Governments.

In order to receive immunity protection, a professional review action regarding the professional competence or professional conduct of a physician or dentist must be taken:

- In the reasonable belief that the action was in the furtherance of quality health care.
- After a reasonable effort to obtain the facts of the matter.
- After adequate notice and hearing procedures are afforded to the physician or dentist involved or after such other procedures as are fair to the physician or dentist under the circumstances.
- In the reasonable belief that the action was warranted by the facts known, after such reasonable effort to obtain facts and after meeting the notice and hearing requirement.

Because the immunity provided by the *Health Care Quality Improvement Act* is from liability rather than from suit, a disciplined physician or dentist retains the right to sue; however, the court may award attorneys' fees and court costs to the defendants if the suit is determined to be frivolous, unreasonable, without foundation, or in bad faith.

Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986*, led to the establishment of the NPDB, an information clearinghouse, to collect and release certain information related to the professional competence and conduct of physicians, dentists, and, in some cases,

other health care practitioners. The establishment of the NPDB represents an important step by the U.S. Government to enhance professional review efforts by making certain information concerning medical malpractice payments and adverse actions available to eligible entities and individuals.

A web link to the NPDB Regulations codified at 45 CFR Part 60 is referenced in Appendix B of this *Guidebook*.

Interpretation of NPDB Information

The NPDB is primarily an alert or flagging system. The information contained in it is intended to direct discrete inquiry into and scrutiny of specific areas of a practitioner's licensure, professional society memberships, medical malpractice payment history, and record of clinical privileges. NPDB information is an important supplement to a comprehensive and careful review of a practitioner's professional credentials. The NPDB is intended to augment, not replace, traditional forms of credentials review. As a nationwide flagging system, it provides another resource to assist State licensing boards, hospitals, and other health care entities in conducting extensive, independent investigations of the qualifications of the health care practitioners they seek to license or hire, or to whom they wish to grant clinical privileges.

Settlement of a medical malpractice claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician, dentist, or other health care practitioner. **Thus, a payment made in settlement of a medical malpractice action or claim shall not be construed as a presumption that medical malpractice has occurred.**

The information in the NPDB should serve only to alert State licensing authorities and health care entities that there may be a problem with a particular practitioner's professional competence or conduct. NPDB information should be considered together with other relevant data in evaluating a practitioner's credentials (e.g., evidence of current competence through continuous quality improvement studies, peer recommendations, health status, verification of training and experience, and relationships with patients and colleagues).

Confidentiality of NPDB Information

Information reported to the NPDB is considered confidential and shall not be disclosed except as specified in the NPDB regulations at 45 CFR Part 60. The confidential receipt, storage, and disclosure of information is an essential ingredient of NPDB operations. A comprehensive security system has been designed to prevent manipulation of and access to the data by unauthorized staff or external sources. The facility in which the NPDB is housed meets HHS security specifications, and NPDB staff have undergone in-depth background security investigations.

The Office of Inspector General (OIG), HHS, has been delegated the authority to impose civil money penalties on those who violate the confidentiality provisions of Title IV. The civil money penalties for violating the confidentiality provisions of

Title IV are to be imposed in the same manner as other civil money penalties pursuant to §1128A of the *Social Security Act*, 42 U.S.C. 1320a-7a. Regulations governing civil money penalties under §1128A are set forth at 42 CFR Part 1003.

For each violation of confidentiality, a civil money penalty of up to $11,000 can be levied. In any case in which it is determined that more than one party was responsible for improperly disclosing confidential information, a penalty of up to the maximum $11,000 limit can be imposed against each responsible individual, entity, or organization.

Persons or entities who receive information from the NPDB either directly or indirectly are subject to the confidentiality provisions and the imposition of a civil money penalty if they violate those provisions. When an authorized agent is designated to handle NPDB queries, both the entity and the agent are required to maintain confidentiality in accordance with Title IV requirements.

The *Privacy Act*, 5 USC §552a, protects the contents of Federal systems of records on individuals, like those contained in the NPDB, from disclosure without the individual's consent, unless the disclosure is for a routine use of the system of records as published annually in the *Federal Register*. The published routine uses of NPDB information, which are based on the laws and the regulations under which the NPDB operates, do not allow disclosure to the general public. The limited access provision of the *Health Care Quality Improvement Act of 1986*, as amended, supersedes the disclosure requirements of the *Freedom of Information Act* (FOIA), 5 USC §552, as amended.

The confidentiality provisions of Title IV do not prohibit an eligible entity receiving information from the NPDB to disclose the information to others who are part of the peer review process, as long as the information is used for the purpose for which it was provided. Examples of appropriate uses of NPDB information include:

- A hospital may disclose the information it receives from the NPDB to hospital officials responsible for reviewing a practitioner's application for a medical staff appointment or clinical privileges. In this case, both the hospital officials who receive the information and the hospital officials who subsequently review it during the employment process are subject to the confidentiality provisions of Title IV.
- A private accreditation entity can review confidential information that a health care entity has obtained regarding its practitioners only if the purpose of the disclosure is to carry out peer review activity for that health care entity (i.e., the private accreditation entity maintains a role in the decision-making process for practitioner membership in the health care entity, which would make its activities part of the peer review process). If the private accreditation entity's activities are not considered part of the peer review process, the private accreditation entity cannot view any documents that the health care entity has obtained from the NPDB that show the results of an NPDB query (e.g., match or no match), such as an NPDB report or the

query response document entitled, *Response to Information Disclosure Request*. However, the health care entity would not be in violation of the confidentiality requirements if it discloses a copy of the *Response to Information Disclosure Request* to the private accreditation entity, as long as information that discloses the query result is removed from the copy, (i.e., so the document shows only the names on which queries were submitted). Additionally, if the health care entity obtains a release from a physician authorizing it to specifically release confidential information it obtains from the NPDB to the private accreditation entity, the health care entity may do so without violating the NPDB's confidentiality restrictions.

The confidentiality provisions do not apply to the original documents or records from which the reported information is obtained. The NPDB's confidentiality provisions do not impose any new confidentiality requirements or restrictions on those documents or records. Thus, these confidentiality provisions do not bar or restrict the release of the underlying documents, or the information itself, by the entity taking the adverse action or making the payment in settlement of a written medical malpractice complaint or claim. For example, if a hospital that reported an adverse action against a physician pursuant to the provisions of Title IV receives a subpoena for the underlying records, it may not refuse to provide the requested documents on the grounds that Title IV bars the release of the records or information.

Individual health care practitioners who obtain information about themselves from the NPDB are permitted to share that information with whomever they choose.

Disclosure of NPDB Information

The *Health Care Quality Improvement Act of 1986*, as amended, and its governing regulations limit the disclosure of information in the NPDB. Information is available to:

- Hospitals requesting information concerning a practitioner on their medical staff or to whom they have granted clinical privileges, or with respect to professional review activity.
- Health care entities (including hospitals) that have entered or may be entering employment or affiliation relationships with a practitioner or to which the practitioner has applied for clinical privileges or appointment to the medical staff, or with respect to professional review activity.
- Practitioners requesting information about themselves.
- Boards of medical examiners or other State licensing boards.
- Attorneys or individuals representing themselves upon submission of proof that a hospital failed to submit a mandatory query.
- Persons or entities requesting information in a form which does not identify any particular entity or practitioner.

The *Privacy Act* protects the contents of Federal systems of records on individuals, like those in the NPDB, from disclosure

without the individual's consent unless the disclosure is for a routine use of the system of records as published annually in the *Federal Register*. The published routine uses of NPDB information, which are consistent with the law and the regulations under which it operates, do not include disclosure to the general public.

- The general public may not request information that identifies any particular entity or practitioner from the NPDB.
- Medical malpractice payers may not request information even though they are required to report.

See §60.11 of the NPDB Regulations. A link to the NPDB Regulations is included in Appendix B of this *Guidebook*.

Coordination Between the NPDB and the HIPDB

The Healthcare Integrity and Protection Data Bank (HIPDB) was established through the *Health Insurance Portability and Accountability Act of 1996* (HIPAA), Public Law 104-191. This law directed the Secretary of HHS and the U.S. Attorney General to create the HIPDB to combat fraud and abuse in health insurance and health care delivery. The HIPDB is a national data collection program for reporting and disclosing certain final adverse actions taken against health care practitioners, providers, and suppliers.

To alleviate the burden on those entities that must report to both the NPDB and the HIPDB, a system has been created to allow an entity that must report the same adverse action to both Data Banks to submit the report only once. This Integrated Querying and Reporting Service (IQRS) is able to sort the appropriate actions into the HIPDB, the NPDB, or both. Similarly, entities authorized to query both Data Banks have the option of querying both the NPDB and the HIPDB with a single query submission.

Official Language

The official language of the NPDB is English, and all documents submitted to the NPDB must be written in English. Documents submitted in any other language are not accepted.

User Fees

User fees are assessed to cover the processing costs for all queries for NPDB information. Refer to the NPDB-HIPDB web site at *www.npdb-hipdb.com* for details regarding the payment of NPDB user fees.

What is an Eligible Entity?

Entities entitled to participate in the National Practitioner Data Bank are defined in the provisions of Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986*, as amended, and in the regulations codified at 45 CFR Part 60. Eligible entities are responsible for meeting Title IV reporting and/or querying requirements, as appropriate. Each eligible entity must certify its eligibility in order to report to and/or query the NPDB.

Information from the NPDB is available to State licensing boards, hospitals and other health care entities, professional societies, certain Federal agencies, and others as specified in the law. The NPDB collects information related to the professional competence and conduct of physicians, dentists, and, in some cases, other health care practitioners.

To be eligible to query the NPDB, an entity must be:

- A board of medical examiners or other State licensing board.
- A hospital.
- A health care entity that provides health care services and follows a formal peer review process to further quality health care.
- A professional society that follows a formal peer review process to further quality health care.

To be eligible to report to the NPDB, an entity must be one of the following:

- An entity that makes a medical malpractice payment.
- A board of medical examiners or a State licensing board taking an adverse action against a physician or dentist.
- A health care entity that takes an adverse clinical privileging action as a result of professional review.
- A professional society that takes an adverse membership action as a result of professional review.

Each entity is responsible for determining its eligibility to participate in the NPDB and must certify that eligibility to the NPDB in writing.

Defining Health Care Entities

Health care entities include hospitals and other organizations that provide health care services and follow a formal peer review process in order to further quality health care. See §60.3 of the NPDB Regulations. A link to the NPDB Regulations is included in Appendix B of this *Guidebook*.

Hospitals

A hospital is defined under Section 1861(e)(1) and (7) of the *Social Security Act* as an institution primarily engaged in providing, by or under the supervision of physicians, to inpatients: diagnostic and therapeutic services; rehabilitation services for medical diagnosis, treatment, and care; or rehabilitation of injured, disabled, or sick persons.

Hospitals must be licensed or approved as meeting the standard established for licensing by the State or applicable local licensing authorities.

Other Health Care Entities

A health care entity must provide health care services and follow a formal peer review process to further quality health care.

The phrase "provides health care services" means the delivery of health care services through any of a broad array of coverage arrangements or other relationships with practitioners either by employing them directly, or through contractual or other arrangements. This definition specifically excludes indemnity insurers that have no contractual or other arrangement with physicians, dentists, or other health care practitioners.

Examples of other health care entities may include health maintenance organizations (HMOs), preferred provider organizations (PPOs), group practices, nursing homes, rehabilitation centers, hospices, renal dialysis centers, and free-standing ambulatory care and surgical service centers.

In addition to HMOs and PPOs, other managed care organizations may qualify as health care entities. A health care entity must provide health care services *and* follow a formal peer review process to further quality health care to satisfy the eligibility requirements of Title IV.

Examples of hospitals and other health care entities are listed in the table that follows.

Examples of Hospitals and Other Health Care Entities

Hospitals	Other Health Care Entities
• All Federal and non-Federal short-term care general and specialty hospitals that are licensed or otherwise authorized by the State.	• Ambulatory or outpatient care centers, even when otherwise part of a hospital.
• All Federal and non-Federal long-term care general and specialty hospitals that provide diagnostic and/or therapeutic care under the supervision of a physician and/or psychologist, that are licensed or otherwise authorized by the State.	• "One-day surgery" centers, even when otherwise part of a hospital.
• A long-term skilled nursing facility that is licensed as a hospital by the State, as long as care is provided under the supervision of a physician or psychologist.	• Nursing homes that provide skilled nursing care not under the supervision of a physician or psychologist.
• A hospice that provides skilled nursing and comfort care under the supervision of a physician and which is licensed by the State.	• Hospices that provide care not under the supervision of a physician or psychologist.
	• Nursing homes or hospices that provide only daily care.

Defining Professional Societies

A professional society is a membership association of physicians, dentists, or other health care practitioners that follows a formal peer review process for the purpose of furthering quality health care.

Examples of professional membership societies may include national, State, county, and district medical and dental societies and academies of medicine and dentistry. Examples of professional organizations that ordinarily do not meet the definition of a professional society include medical and surgical specialty certification boards, independent practice associations (IPAs), and PPOs.

Professional societies are not automatically eligible to query and/or report to the NPDB. A professional society must qualify as a "health care entity" as defined in §60.3 of the NPDB regulations. To meet NPDB eligibility requirements, a professional society must follow a formal peer review process for the purpose of furthering quality health care.

Defining State Licensing Boards

A State licensing board, or board of medical examiners, is responsible for licensing, monitoring, and disciplining physicians, dentists, or other health care practitioners. A board of medical examiners includes a medical or dental board, a board of osteopathic examiners, a composite board, a subdivision, or an equivalent body as determined by the State.

Defining Medical Malpractice Payers

A medical malpractice payer is an entity that makes a medical malpractice payment for the benefit of physicians, dentists, or other health care practitioners in settlement of or in satisfaction in whole or in part of, a claim or judgment against such practitioner.

Registering with the NPDB

Eligible entities are responsible for meeting Title IV reporting and/or querying requirements. Entities not currently registered with the NPDB are responsible for determining their eligibility and registering with the NPDB by completing an *Entity Registration* form. A Data Bank Identification Number (DBID), a user ID, and a password are issued to each successfully registered entity. An entity that does not have this information is not registered with the NPDB and will be unable to submit reports and queries.

The *Entity Registration* form may be downloaded from the NPDB-HIPDB web site at *www.npdb-hipdb.com*. The *Entity Registration* form allows entities to register simultaneously for both the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB). The information requested on this form provides the NPDB with essential information concerning your entity, such as your organization's name, address, Federal Taxpayer Identification Number (TIN), and type of ownership; your organization's authority to participate in the NPDB and the HIPDB under each of the statutes governing the Data Banks (Title IV for the NPDB; and Section 1128E for the HIPDB); your organization's primary function or service (e.g., entity type); and, for those entities authorized by law to query both Data Banks, whether queries are to be submitted to the NPDB only, to the HIPDB only, or to both Data Banks. This information allows the NPDB to register your entity's authorization to participate in the NPDB, and to determine your entity's reporting and/or querying requirements and restrictions.

Certifying Official

A certifying official is the individual selected and empowered by an entity to certify the legitimacy of registration for participation in the NPDB.

The *Entity Registration* form contains certification information that must be completed by an entity's certifying official. The entity's certifying official certifies the legitimacy of the registration information provided to the NPDB. The certification section must contain an original ink signature and a signature date. Faxed, stamped, or photocopied signatures are unacceptable. The title of the certifying official, a telephone number, and an e-mail address must also be provided.

Once the completed *Entity Registration* form is received and processed, the NPDB assigns a unique, confidential DBID and password and sends an *Entity Registration Verification* document to the entity. This document contains the entity's confidential DBID, user ID, and password, as well as the information that was provided to the NPDB on the *Entity Registration* form. The certifying official should read the document carefully and, if the document contains any errors, follow the instructions provided on the document for correcting the inaccurate information.

The certifying official may also designate an authorized agent to query and/or report on behalf of the entity by completing an *Authorized Agent Designation* form and submitting it to the NPDB. (Specific responsibilities of authorized agents are described on page B-7.)

Entity Recertification

The NPDB periodically requires entities to recertify their eligibility. At these times, the NPDB sends to each active entity the current identification information on file with the NPDB. The entity's certifying official should review the information to ensure that it is correct, indicate the entity's applicable certification statement, sign the document, and return it to the NPDB.

Data Bank Identification Numbers (DBIDs)

Each entity that registers with the NPDB is assigned a unique DBID and password as well as an initial user ID. DBIDs are used to identify registered entities and authorized agents, and must be provided on all reports, queries, and correspondence submitted to the NPDB.

A DBID is a link into the NPDB computer system and should be safeguarded to prevent inadvertent disclosure. It is revealed only to the entity or agent to which it is assigned. In the event that your entity's DBID is compromised, follow the instructions in the **Deactivate a DBID** section.

The assignment of a DBID is not a representation by HHS that an entity meets the eligibility criteria for participation in the NPDB, as specified in the *Health Care Quality Improvement Act of 1986*, as amended, and its implementing regulations, 45 CFR Part 60. Each entity is responsible for determining whether it meets the eligibility criteria and for certifying its eligibility to the NPDB.

DBIDs are assigned only to entities that certify their eligibility to the NPDB and to authorized agents who act on behalf of registered entities. **DBIDs are not assigned to certifying officials, authorized submitters or other individuals associated with a reporting or querying entity.** However, entities may create multiple user accounts (user IDs) for a given DBID (see the User ID section in this chapter). For each user ID that an entity establishes, the entity must also create a separate password. For more information on establishing multiple user IDs, refer to the NPDB-HIPDB web site.

Deactivate a DBID

An eligible entity may request at any time that its current DBID be deactivated and a new DBID assigned by selecting the Assign New DBID or Deactivate DBID boxes on the *Entity Registration* form and completing the required sections. For instance, if you believe that your entity's DBID has been compromised in any way, or if your entity merges with another entity, you may wish to deactivate your DBID and request a new one. You must provide your reason for requesting a new DBID on the completed form when it is returned to the NPDB for processing.

Additionally, if at any time, your entity relinquishes eligibility to participate in the NPDB, your entity's certifying official must notify the NPDB in writing to deactivate your entity's DBID. The *Entity Registration* form, which can be retrieved from the NPDB-HIPDB web site, must be

used to request deactivation. The Deactivate DBID option must be checked and the required sections of the form completed. The reason for deactivation must be provided on the completed form when it is returned to the NPDB for processing.

Reactivate a DBID

If your entity's DBID is currently inactive and you determine that it should be active, your entity's certifying official should complete an *Entity Registration* form. Select the Reactivate an Entity option on the form to request that the DBID be reactivated. The reason for reactivation must be provided on the completed form when it is returned to the NPDB for processing.

User IDs

Entities can create multiple user accounts so that multiple departments/people can use the same DBID for querying and reporting. User IDs are created and maintained through the IQRS. The user ID an entity receives when it initially registers with the Data Banks is the administrator account. The administrator oversees all other user IDs and is the only user that may add, update, and remove other user accounts (user IDs). If an entity has only one person who uses the IQRS, the entity may choose to use the administrator account as its regular user account. For more information on establishing multiple users, see the NPDB-HIPDB web site.

Update Entity Information

If your entity's name, address, statutory authority, organization type, certifying official, or any other item of your registration information changes, your entity's certifying official should obtain and complete an *Entity Registration* form from the website, and select the Change Entity Information option.

You may update selected profile information via the IQRS. After logging in to the IQRS, you will see the *Entity Registration Confirmation* screen. Select a button at the bottom of the screen called *Update Entity Profile*. You will be able to change the following information: department name, mailing address, e-mail address, and Taxpayer Identification Number (TIN). To update any other entity information, complete and mail an *Entity Registration* form as described above.

When the NPDB receives updated entity information, the updated information is processed into the NPDB computer system and an *Entity Registration Verification* document, reflecting the changes submitted, is mailed to the entity's certifying official. The certifying official should read the document carefully. If the document contains any errors, follow the instructions provided on the document for correcting the inaccurate information.

Lost Your DBID?

If you cannot remember your DBID, contact the NPDB-HIPDB Customer Service Center for assistance.

Organizations That May Report and Query on Behalf of Entities

Authorized submitters or authorized agents may submit queries and reports and retrieve responses from the NPDB on behalf of registered entities.

Authorized Submitter

An authorized submitter is the individual selected and empowered by a registered entity to certify the legitimacy of information provided in a query or report to the NPDB. In most cases, the authorized submitter is an employee of the organization submitting the report or query, such as an administrator, a risk manager, or medical staff services personnel. The NPDB does not assign DBIDs to authorized submitters.

Entities are responsible for selecting their authorized submitter, and the submitter may change at any time. Entities may choose to have multiple submitters. For example, an entity may designate a particular individual within the organization to be the authorized submitter for reporting and another individual to be the authorized submitter for querying. The authorized submitter is often the individual designated by the organization to submit and retrieve report and/or query responses from the NPDB. However, personnel may be designated as desired. Entities are not required to register the authorized submitter or to identify that person by name to the NPDB in advance, although the authorized submitter must provide his or her name, title and phone number at the time a query or report is submitted.

Authorized Agents

Registered entities may elect to have outside organizations query or report to the NPDB on their behalf. Such an organization is referred to as an authorized agent. In most cases, an authorized agent is an independent contractor used for centralized credentialing, for example, a county medical society, a State hospital association, a credentials verification organization (CVO), or organizations that may be used for centralized credentialing or professional oversight, such as the National Council of State Boards of Nursing and the Federation of Chiropractic Licensing Boards.

Entities must ensure that certain guidelines are followed when designating an authorized agent to query or report on their behalf. The entity should establish a written agreement with that authorized agent confirming the following:

- The agent is authorized to conduct business in the State.
- The agent's facilities are secure, ensuring the confidentiality of NPDB responses.
- The agent is explicitly prohibited from using information obtained from the NPDB for any purpose other than that for which the disclosure was made. For example, two different health care entities designate the same authorized agent to query the NPDB on their behalf. Both health care entities wish to request information on the same practitioner. The authorized agent must query the NPDB separately on behalf of each health care entity. The response to an NPDB query submitted for one health care entity cannot be shared with another health care entity.
- The agent is aware of the sanctions that can be taken against the agent if information is requested, used, or disclosed in violation of NPDB provisions.
- Authorized agents are not eligible to access information in the NPDB under their own authority. These

organizations and other organizations that do not meet the statute's specific query eligibility criteria may only interact with the NPDB as authorized agents. Authorized agents may only query the NPDB with the authorization of an eligible entity (i.e., the eligible entity must designate the authorized agent to act on its behalf by completing the *Authorized Agent Designation* form) for specifically designated and limited purposes.

The authorized agent must have a copy of the most recent *Guidebook* (which includes the regulations and the civil money penalty regulations of the Office of Inspector General (OIG), HHS, at 42 CFR Part 1003) and should be aware of the sanctions that can be taken if information is requested, used, or disclosed in violation of NPDB provisions. The *Health Care Quality Improvement Act* and the OIG's civil money penalty regulation authorizes a penalty of up to $11,000 for each violation.

Designating Authorized Agents

Before an authorized agent may act on behalf of an entity, the entity must designate the agent to interact with the NPDB on its behalf. Registered entities that want to designate an authorized agent should obtain an *Authorized Agent Designation* form from the NPDB-HIPDB web site. The entity must complete the form, providing the authorized agent's name, DBID (if known), address, and telephone number; and the entity's response routing and fee payment preferences, and return it to the NPDB.

Authorized agents must be registered with the NPDB before they can be designated to report and/or query on behalf of eligible entities. If the agent is not registered with the NPDB, the agent must obtain an *Authorized Agent Registration* form from the NPDB-HIPDB web site. Once the agent is registered, a DBID and a password is assigned to that agent, and the entity can designate that agent to report and query on its behalf.

NPDB responses to reports and queries submitted by an authorized agent will be routed to either the eligible entity or its authorized agent, as indicated by the entity on the *Authorized Agent Designation* form. If the entity wishes to retrieve responses itself from the Integrated Querying and Reporting Service, the entity must have access to the Internet (i.e., an Internet Service Provider) and an appropriate web browser. Requirements for using the Integrated Querying and Reporting Service can be found on the NPDB-HIPDB web site.

In addition, a plug-in or stand-alone program that can read files in Portable Document Format (PDF) is required, such as Adobe Acrobat Reader 4.0.

An authorized agent should have only one DBID, even though more than one entity may designate the agent to query and report to the NPDB. If an authorized agent has been issued more than one DBID, the authorized agent should obtain an *Authorized Agent Registration* form from the NPDB-HIPDB web site, indicate which DBID it intends to use, and request that any other DBIDs be deactivated.

Any changes to an authorized agent designation, such as a change to response routing or termination of an authorized agent's authorization to query and report on an entity's behalf, must be submitted by the entity. If changes in an authorized agent designation are required, the entity should obtain an *Authorized Agent*

Designation form from the NPDB-HIPDB web site, select the Update Previous Agent Designation option on the form, complete the form as directed, and return it to the NPDB.

All forms should be mailed to the NPDB:

NPDB-HIPDB
P.O. Box 10832
Chantilly, VA 20153-0832

Questions and Answers

1. **How do I know if my organization is an eligible entity?**

   See §60.3, Definitions, of the NPDB Regulations. A link to the NPDB Regulations is included in Appendix B of this *Guidebook*.

2. **Can the NPDB certify or verify that my organization is eligible to report or query?**

   Each entity must determine its own eligibility to participate in the NPDB. The assignment of a DBID is not a representation by HHS that your organization meets the eligibility criteria for participation in the NPDB, as specified in the *Health Care Quality Improvement Act of 1986*, as amended, and its implementing regulations, 45 CFR Part 60. The NPDB Regulations, included as Appendix B, describe the criteria for eligibility. Other informational materials designed to help you determine your organization's eligibility can be obtained from the NPDB-HIPDB web site.

3. **Does my organization have to notify the NPDB when we have a new certifying official?**

   Yes. The eligible entity gives the certifying official authority to certify the legitimacy of registration information provided to the NPDB. The person authorized by the entity to act as the certifying official may change at any time at the discretion of the entity. However, the NPDB makes a record of the staff title and name of the individual assigned as the certifying official and should be notified when changes occur.

4. **My hospital merged with another hospital, and both have medical staff offices. Should we continue to query separately using two different DBIDs?**

   If the hospitals maintain separate medical staff credentialing, the hospitals should query separately. If by applying to one hospital a practitioner is granted privileges to practice at both institutions, one hospital should query on behalf of both institutions. However, both hospitals should be aware that if one DBID is deactivated, the NPDB will maintain only one hospital address and only one "electronic address." For more information on query responses, see Chapter D, Queries.

5. **My organization provides a resource that identifies practitioners who meet minimum standards as established by the organization. Does producing this list make my organization eligible to participate in the NPDB?**

   In order to be eligible to participate in the NPDB, an organization must meet the definition of a State licensing board, a hospital, or other health care entity, including a professional society, as defined in this *Guidebook*. If your organization does not confer rights or responsibilities of membership on a practitioner and conduct formal peer review, it does not meet the definition of a professional society as described in the NPDB Regulations and is not eligible to participate in the NPDB.

6. **If my organization queries the NPDB, is it also required to report? Conversely, if my organization reports to the NPDB, is it automatically eligible to query?**

   Not necessarily. See Chapters D and E, Queries and Reports, respectively, for discussions on querying and reporting eligibility criteria.

7. **Are PPOs eligible to participate in the NPDB?**

   PPOs would normally be considered as "providing" health care services. If a PPO conducts formal peer review to further quality health care, it would be eligible to participate in the NPDB.

8. **Can my organization have more than one DBID?**

   If you have multiple departments or people who handle NPDB querying and/or reporting, you may register each department or person separately and receive separate DBIDs for each one. However, departments or people with different DBID cannot assist one another other (i.e., one department cannot download a response from a query entered by another department with a different DBID). Also, special care must be taken to be sure that the same query or report is not submitted twice.

   Rather than registering for multiple DBIDs, an entity may choose instead to simply create multiple user accounts (i.e., user IDs) under the organization's DBID. Using the IQRS, an entity can establish as many user accounts as necessary, and can deactivate those accounts itself when needed without deactivating its DBID.

Overview

NPDB querying and reporting requirements apply to physicians, dentists, and other licensed health care practitioners. The NPDB acts as a clearinghouse of information relating to medical malpractice payments, certain adverse actions taken against practitioners' licenses, clinical privileges, and professional society memberships, and eligibility to participate in Medicare/Medicaid. NPDB information is intended to be used in combination with information from other sources in making determinations on granting clinical privileges or in employment, affiliation, or licensure decisions. Table C-1, *NPDB Requirements Affecting Physicians, Dentists, and Other Health Care Practitioners*, summarizes Title IV requirements affecting physicians, dentists, and other health care practitioners.

Defining Health Care Practitioners

A **physician** is defined as a doctor of medicine or osteopathy who is legally authorized by a State to practice medicine or surgery. A **dentist** is defined as a doctor of dental surgery, doctor of dental medicine, or the equivalent, who is legally authorized by a State to practice dentistry.

Any individual who, without authority, holds himself or herself out to be an authorized physician or dentist is considered a physician or dentist.

Other health care practitioners are defined as individuals other than physicians or dentists who are licensed or otherwise authorized (certified or registered) by a State to provide health care services; or individuals who, without authority, hold themselves out to be so licensed or authorized. For examples, see the list on page C-3 entitled *Examples of Other Health Care Practitioners*.

The licensing or authorization of other health care practitioners to provide health care services varies from State to State. Each entity that reports to or queries the NPDB is responsible for determining which categories of health care practitioners are licensed or otherwise authorized by their State to provide health care services.

Currently, there is no NPDB requirement to query or report on other health care practitioners who are not licensed or otherwise authorized by a State to provide health care services, unless the individual holds himself or herself to be so authorized.

Table C-1. NPDB Requirements Affecting Physicians, Dentists, and Other Health Care Practitioners

Entity	Reporting to the NPDB	Querying the NPDB
State Medical and Dental Boards	Must report certain adverse licensure actions related to professional competence or professional conduct and revisions to such actions for physicians and dentists.	May query at any time.
Other State Licensing Boards	Do not report.	May query at any time.
Hospitals and Other Health Care Entities	Must report (1) professional review actions related to professional competence or professional conduct that adversely affect clinical privileges of a physician or dentist for more than 30 days; (2) a physician's or dentist's voluntary surrender or restriction of clinical privileges while under investigation for professional competence or professional conduct or in return for not conducting an investigation; and (3) revisions to such actions. May report on other health care practitioners.	Hospitals must query when screening applicants for a medical staff appointment or granting/adding to/expanding clinical privileges, and every 2 years on health care practitioners on the medical staff or who have clinical privileges. Hospitals may query at other times, as they deem necessary. Other health care entities may query when screening applicants for a medical staff appointment or granting affiliation, clinical privileges, and in support of professional review activity.
Professional Societies	Must report professional review actions, based on reasons relating to professional competence or conduct, that adversely affect professional society memberships and revisions to such actions for physicians and dentists. May report on other health care practitioners.	May query when screening an applicant for membership or affiliation, and in support of professional review activity.
Medical Malpractice Payers	Must report payments made for the benefit of physicians, dentists, and other health care practitioners in settlement of or in satisfaction in whole or in part of a claim or judgement against such practitioner.	May not query the NPDB.
Health Care Practitioners	Do not report on their own behalf.	May self-query the NPDB at any time.
Office of Inspector General (OIG), HHS	Reports exclusions from the Medicare/Medicaid programs against physicians, dentists, and other health care practitioners.	May not query the NPDB.

Examples of Other Health Care Practitioners

The following list of health care practitioners other than physicians and dentists is provided solely for illustration. The inclusion or exclusion of any health care occupational group should not be interpreted as a mandate or a waiver of compliance to Data Bank reporting requirements, since licensure and certification requirements vary from State to State.

Chiropractor

Counselor
Counselor, Mental Health
Professional Counselor
Professional Counselor, Alcohol
Professional Counselor, Family/Marriage
Professional Counselor, Substance Abuse

Dental Service Provider
Dental Assistant
Dental Hygienist
Denturist

Dietician/Nutritionist
Dietician
Nutritionist

Emergency Medical Technician (EMT)
EMT, Basic
EMT, Cardiac/Critical Care
EMT, Intermediate EMT, Paramedic

Nurse/Advanced Practice Nurse
Registered (Professional) Nurse
Nurse Anesthetist
Nurse Midwife
Nurse Practitioner
Licensed Practical or Vocational Nurse

Nurses Aide/Home Health Aide
Nurses Aide
Home Health Aide (Homemaker)

Eye and Vision Service Provider
Ocularist
Optician
Optometrist

Pharmacy Service Provider
Pharmacist
Pharmacist, Nuclear
Pharmacy Assistant

Physician Assistant
Physician Assistant, Allopathic
Physician Assistant, Osteopathic

Podiatric Service Provider
Podiatrist
Podiatric Assistant

Psychologist, Clinical

Rehabilitative, Respiratory, and Restorative Service Provider
Art/Recreation Therapist
Massage Therapist
Occupational Therapist
Occupational Therapy Assistant
Physical Therapist
Physical Therapy Assistant
Rehabilitation Therapist
Respiratory Therapist
Respiratory Therapy Technician

Social Worker

Speech, Language, and Hearing Service Provider
Audiologist
Speech/Language Pathologist

Technologist
Medical Technologist
Cytotechnologist
Nuclear Medicine Technologist
Radiation Therapy Technologist
Radiologic Technologist

Other Health Care Practitioner
Acupuncturist
Athletic Trainer
Homeopath
Medical Assistant
Midwife, Lay (Non-nurse)
Naturopath
Orthotics/Prosthetics Fitter
Perfusionist
Psychiatric Technician

Practitioner Self-Query

A self-query is a practitioner's request for information about himself or herself. Practitioners may self-query the NPDB and the HIPDB at any time by visiting the NPDB-HIPDB web site at *www.npdb-hipdb.com*. **All self-query applications must be submitted through the NPDB-HIPDB web site.** Previous paper versions of the *Self-Query* form will be rejected. Practitioners who do not have access to the Internet may call the NPDB-HIPDB Customer Service Center for assistance. For detailed instructions on self-querying, see the *Fact Sheet on Self-Querying*, available at *www.npdb-hipdb.com*.

A practitioner who submits a self-query to the Data Banks will receive via U.S. mail either a response notifying them that no information exists in the Data Banks, or a copy of all report information submitted by eligible reporting entities. All practitioner self-queries will be processed against both the NPDB and the HIPDB. As part of their self-query response, subjects of an Adverse Action Report or Medical Malpractice Payment Report submitted to the NPDB will receive a list of all queriers to whom the reported information has been disclosed with the response.

All *Self-Query* forms must be signed and notarized, and all fields in the notarization section must be completed. The NPDB-HIPDB will reject any self-query received without signature and notarization or with an incomplete notarization.

A fee will be charged for each self-query submitted. For more information on self-query fees, refer to Chapter G, Fees.

Self-Querying on the Internet

The NPDB-HIPDB employs the latest technology, along with various implementation measures, to provide a secure environment for querying, reporting, data storage, and retrieval. Security features include firewall protection from unauthorized access and encryption of transmitted data to prevent unauthorized use.

Practitioners complete and transmit their self-queries to the NPDB-HIPDB on-line; however, a self-query is not officially submitted until a signed and notarized paper copy is received by the Data Banks. A formatted copy of the self-query is generated immediately after electronic transmission. To complete the self-query process, practitioners must print the formatted copy, sign and date it in the presence of a notary public, and mail the notarized self-query to the address specified.

Once a properly signed and notarized self-query is received by the Data Banks, it typically is processed within one business day and returned to the practitioner via U.S. mail. The practitioner may view the processing status of his or her self-query request via the NPDB-HIPDB web site at *www.npdb-hipdb.com*.

Subject Information in the NPDB

The NPDB is committed to maintaining accurate information and ensuring that subjects are informed when medical malpractice payments or adverse actions are reported about them. When the NPDB receives a report, the information is processed by the NPDB computer system exactly as submitted by the reporting

entity. Reporting entities are responsible for the accuracy of the information they report.

When the NPDB processes a report, a *Report Verification Document* is made available to the reporting entity for retrieval from the Integrated Querying and Reporting Service (IQRS), and a *Notification of a Report in the Data Bank(s)* is sent to the subject. The subject should review the report for accuracy, including current address, telephone number, and place of employment.

Subjects may not submit changes to reports. If any information in a report is inaccurate, the subject must contact the reporting entity to request that it file a correction to the report.

If the reporting entity refuses to correct the report, the subject of a report may:

- Add a statement to the report.
- Initiate a dispute of the report.
- Add a statement and initiate a dispute.

For more information about the NPDB dispute process, see Chapter F, Disputes.

Questions and Answers

1. **How do I correct my address if it is wrong in a report?**

   You must contact the reporting entity (identified in both the *Notification of a Report in the NPDB* and *Self-Query Response* document) and request that the entity correct the address on the report. If the entity does not honor your request to correct the inaccurate address, you can dispute the report.

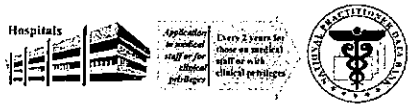
2. **I am a practitioner who personally refunded a fee to a patient. Is this refund reportable to the NPDB?**

   No. A refund from a practitioner's personal funds is not reportable. However, if the refund is paid by an insurer or any entity other than an individual practitioner (including a professional services corporation comprised of a sole practitioner), the refund is reportable. For more information concerning NPDB reporting requirements, see Chapter E, Reports.

3. **Can a hospital, State licensing board, or medical malpractice insurer require that I give them the results of a self-query?**

   The response you receive to a self-query is yours to do with as you wish. Various licensing, credentialing, and insuring entities may require a copy of your query before you may participate in their programs. Any arrangement between you and one of these entities is voluntary. HHS does not regulate such arrangements. *However, a copy of a subject self-query does not satisfy a hospital's legal requirement to query.*

MANDATORY QUERYING



The biennial query may be done in accordance with regular medical staff reappointment and clinical privilege redelineation. **Hospitals are not required to query more than once every 2 years on a practitioner who is continuously on staff. Hospitals with annual reappointment are not required to query annually.** Hospitals may query the NPDB at any time they wish with respect to professional review activity.

Hospitals are also required to query the NPDB when a practitioner wishes to add to or expand existing privileges and when a practitioner submits an application for temporary privileges. For example, if a practitioner applies for temporary clinical privileges four times in one year, the hospital must query the NPDB on each of those four occasions. A hospital is required to query the NPDB each time a *locum tenens* practitioner makes an application for temporary privileges, not each time the practitioner comes to the facility. To reduce the query burden, hospitals that frequently use particular *locum tenens* practitioners may choose to appoint such practitioners to their consultant staff or other appropriate staff category in accordance with their bylaws and then query on them when they query on their full staff biennially.

Hospitals are required to query on courtesy staff considered part of the medical staff, even if afforded only non-clinical professional courtesies such as use of the medical library and continuing education facilities. If a hospital extends non-clinical practice courtesies without first appointing practitioners to a medical staff category, querying is not required on those practitioners.

Overview

The NPDB is a resource to assist State licensing boards, hospitals, and other health care entities in investigating the qualifications of the health care practitioners they seek to license or hire, or to whom they wish to grant membership or clinical privileges. The NPDB disseminates certain information to eligible entities on medical malpractice payments, Medicare/Medicaid exclusions, adverse licensure actions, adverse clinical privileges actions, and adverse professional society membership actions for physicians, dentists, and other health care practitioners who are licensed or otherwise authorized by a State to provide health care services.

- Hospitals must query when a practitioner applies for privileges or medical staff membership and every 2 years on practitioners on the medical staff or holding privileges.
- Other health care entities, including professional societies, may query when entering an employment or affiliation relationship with a practitioner or in conjunction with professional review activities.
- State licensing boards may query at any time.
- Health care practitioners may self-query at any time.
- Plaintiff's attorneys may query under certain limited circumstances. See NPDB Regulations §60.11(a)(5) or Table D-1, *Title IV Querying Requirements*, on page D-4.
- Medical malpractice payers may not query at any time.

Hospitals

Hospitals are the only health care entities with mandatory requirements for querying the NPDB. Each hospital must request information from the NPDB as follows:

- When a physician, dentist, or other health care practitioner applies for medical staff appointment (courtesy or otherwise) or for clinical privileges at the hospital.
- Every 2 years (biennially) on all physicians, dentists, and other health care practitioners who are on its medical staff (courtesy or otherwise) or who hold clinical privileges at the hospital.

Residents and Interns

Health care entities are not required to query the NPDB on medical and dental residents, interns, or staff fellows (housestaff), even though they are often licensed, because they are trainees in structured programs of supervised graduate medical education, rather than members of the medical staff.

There is no difference between the housestaff of the clinical facility belonging to the formal education program and the housestaff rotating to a clinical facility providing a clinical training site for the formal educational program. Hospitals are not required to query the NPDB on housestaff providing services as part of their formal clinical education. However, hospitals are required to query on residents or interns when such individuals are appointed to the medical staff or granted clinical privileges to practice outside the parameters of the formal medical education program (for example, moonlighting in the intensive care unit or Emergency Department of that hospital).

Professional Societies

Professional societies that meet Title IV eligibility requirements may request information from the NPDB when screening applicants for membership or affiliation and in support of professional review activities.

State Licensing Boards

State licensing boards may request information from the NPDB at any time.

OPTIONAL QUERYING

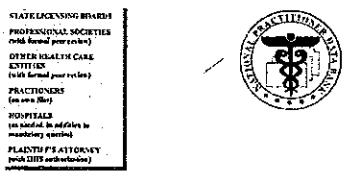


Table D-1. Title IV Querying Requirements

ENTITY	REQUIREMENT
Hospitals	
Screening applicants for medical staff appointment or granting of clinical privileges; every 2 years for physicians, dentists or other health care practitioners on the medical staff or granted clinical privileges.	Must query
At other times as they deem necessary.	May query
State Licensing Boards (including Medical and Dental)	
When they deem necessary.	May query
Other Health Care Entities	
Screening applicants for medical staff appointment, membership or affiliation, or granting of clinical privileges; supporting professional review activities.	May query
Professional Societies	
Screening applicants for membership or affiliation; supporting professional review activities.	May query
Plaintiff's Attorneys	
Plaintiff's attorney or plaintiff representing himself or herself who has filed a medical malpractice action or claim in a State or Federal court or other adjudicative body against a hospital when evidence is submitted to HHS which reveals that the hospital failed to make a required query of the NPDB on the practitioner(s) also named in the action or claim.	May query
Physicians, Dentists, and Other Health Care Practitioners	
Regarding their own files.	May query
Medical Malpractice Payers	May not query

Types of Queries

Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986*, as amended, prescribes the following types of queries:

- **Privileging or Employment:** for use by a hospital or other health care entity, including a professional society, when screening applicants for medical staff appointment, granting of clinical privileges, membership, or professional affiliation.
- **Professional Review Activity:** for use by a hospital or other health care entity, including a professional society, when conducting professional review activity.
- **Mandatory 2-Year:** for use by a hospital when submitting biennial queries on physicians, dentists, or other health care practitioners on their medical staff or to whom clinical privileges have been granted.
- **State Licensing Board:** for use by State boards of medical examiners, State boards of dentistry, or other State licensing bodies.
- **Self-Query:** for use by a physician, dentist, or other health care practitioner.
- **Other:** for use by a plaintiff's attorney or the Secretary of HHS, as authorized by Title IV.

Attorney Access

A plaintiff's attorney or a plaintiff representing himself or herself is permitted to obtain information from the NPDB under the following limited conditions:

- A medical malpractice action or claim must have been filed by the plaintiff against a hospital in a State or Federal court or other adjudicative body, and
- The subject on whom the information is requested must be named in the action or claim.

Obtaining NPDB information on the specified subject is permitted only after evidence is submitted to HHS demonstrating that the hospital failed to submit a mandatory query to the NPDB regarding the subject named by the plaintiff in the action. This evidence is not available to the plaintiff through the NPDB. Evidence that the hospital failed to request information from the NPDB must be obtained by the plaintiff from the hospital through discovery in the litigation process.

A plaintiff's attorney must submit all of the following to the NPDB:

- A letter requesting authorization to obtain information.
- Supporting evidence that the hospital did not make a mandatory query to the NPDB regarding the subject named by the plaintiff in the action or claim.
- Identifying information about the subject on whom the attorney wishes to query.

Examples of evidence may include a deposition, a response to an interrogatory, and admission or other evidence of the failure of a hospital to request information. The plaintiff's attorney must submit a separate request for information disclosure for each subject named in the action or claim.

The approval of a plaintiff's attorney query is limited to a one-time-only disclosure; the approval of such a request does not allow a plaintiff's attorney to obtain NPDB information on a continuing basis. Subsequent disclosures of NPDB information require the plaintiff's attorney to initiate a new request. A fee is assessed when the NPDB discloses such information.

An approved query request entitles the plaintiff's attorney to receive only that information available in the NPDB at the time the hospital was required to query but did not. It also includes information on any reports that were subsequently voided.

There are limitations on the use of information obtained by the plaintiff in a judicial proceeding. Specifically, the information obtained from the NPDB on the subject can only be used with respect to a legal action or claim against the hospital, not against the subject. Any further disclosure or use violates the confidentiality provisions of Title IV, and subjects the plaintiff's attorney and/or plaintiff to a civil money penalty of up to $11,000.

Defense attorneys are not permitted access to the NPDB under Title IV because the defendant subject is permitted to self-query the NPDB.

Authorized Agents

Eligible entities may elect to have an authorized agent query the NPDB on their behalf. Authorized agents must query the NPDB separately on behalf of each eligible entity. The response to an NPDB query submitted for one entity cannot be disclosed to another entity. For more information on authorized agents, see page B-7.

Submitting a Query to the NPDB

Eligible entities prepare and submit queries using the Integrated Querying and Reporting Service (IQRS) at *www.npdb-hipdb.com*. A DBID, a user ID, and a unique password are used by eligible entities and their authorized agents to report and retrieve query responses via the World Wide Web. Internet access with a web browser is required for using the IQRS.

The IQRS does not accept an incomplete query (one that is missing required information or is improperly completed). Such queries are rejected. Entities are encouraged to gather as much information as possible as part of the application process, to make the completion of the query easier.

Entities may submit queries using electronic transaction file submission, also known as the ICD Transfer Program (ITP). The ITP is a program that transmits Interface Control Document (ICD) query submission files and receives query response files from the NPDB-HIPDB. All data are transmitted over an Internet Secure Socket Layer (SSL) connection. Submitting queries using the ITP is an alternative for those entities that generate

queries from custom (third-party) or other special purpose software. Entities that choose to query via the ITP must provide data in the format specified in the NPDB-HIPDB *Interface Control Document (ICD) for Query Transactions*. Information about querying via the ITP is available at *www.npdb-hipdb.com*.

Entities that are authorized and registered to query both the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB) may elect to query both Data Banks simultaneously with a single query submission. Entities that wish to query both Data Banks should indicate this preference on their *Entity Registration* form.

Equipment Needed to Query Electronically

Requirements for using the IQRS can be found on the NPDB-HIPDB web site. Entities must use the appropriate version of either Internet Explorer or Netscape Communicator to query the NPDB. Entities can determine their browser's version number by starting their browser, selecting Help from the main menu, then selecting About Communicator or About Internet Explorer, as appropriate.

You also need a program that can read files in Portable Document Format (PDF) (i.e., files with a .pdf extension), such as Adobe Acrobat Reader 4.0 (or higher). Download the latest version of the free Acrobat Reader at *http://www.adobe.com*. These guidelines explain the minimum requirements necessary to access the IQRS. To improve reliability, the NPDB recommends that you use the most recent version of each browser available for your operating system.

Querying Through an Authorized Agent

The NPDB's response to a query submitted by an authorized agent on behalf of an entity is based upon two eligibility standards: (1) the entity must be entitled to receive the information, and (2) the agent must be authorized to receive that information on behalf of that entity. Both the entity and the agent must be properly registered with the NPDB prior to the authorized agent's query submission.

Authorized agents cannot use a query response on behalf of more than one entity. NPDB regulations specify that information received from the NPDB must be used solely for the purpose for which it was provided. If two different entities designate the same authorized agent to query the NPDB on their behalf, and both entities wish to request information on the same subject, the authorized agent must query the NPDB separately on behalf of each entity. The response to a query submitted for one entity cannot be disclosed to another entity.

Query Processing

When the NPDB receives a properly completed query, the information is entered into the NPDB computer system. The computer system performs a validation process that matches subject (i.e., practitioner) identifying information submitted in the query with information previously reported to the NPDB. Information reported about a specific subject is released to an eligible querier only if the identifying information provided in the query matches the information in a report.

Each query processed by the NPDB computer system is assigned a unique Data Bank Control Number (DCN). The DCN is used by the NPDB to locate the query within the computer system and is prominently displayed on an electronic response. If a question arises concerning a particular query, the entity must reference the DCN in any correspondence to the NPDB.

Subject Information

When submitting a query, the entity is required to provide certain subject information. **The NPDB computer system does not allow entities to submit queries that do not include information in all mandatory fields. An entity's lack of mandatory information does not relieve it of querying requirements for the purposes of Title IV.**

A subject's Social Security Number (SSN) should be provided if known, but only if it was obtained in accordance with Section 7 of the *Privacy Act of 1974*, which states that disclosure of an individual's SSN is voluntary unless otherwise provided by law. Disclosure of an individual's SSN for the purposes of this program is voluntary. The NPDB uses SSNs only to verify the identity of individuals, and SSNs will be disclosed only as authorized by the *Health Care Quality Improvement Act of 1986*, as amended. The inclusion of this information helps to ensure the accurate identification of the subject of the report.

Subject Database

You may establish a subject database to complete your querying and reporting obligations more efficiently. The subject database is a feature of the IQRS that offers an easy method for maintaining information about the subjects on whom you routinely query or report. (e.g., Social Security Numbers, dates of birth, license numbers).

You may import a pre-existing QPRAC subject database into the IQRS, eliminating the need to retype subject data. For information, see the *Fact Sheet on Creating and Maintaining a Subject Database*, available at *www.npdb-hipdb.com*.

Character Limits

Each field in a query (such as Subject Name, Work Address, and License Number) is limited to a certain number of characters, including spaces and punctuation. The IQRS software does not allow the entity to use more than the allotted number of characters. **The NPDB does not change any information submitted in a query.**

Query Responses

In general, query responses are available electronically within an average of 4 to 6 hours of receipt by the NPDB. Under certain circumstances, additional processing may be required. Entities that submit queries using the IQRS should retrieve their query responses from the IQRS. Queries marked Completed have been processed and are available for retrieval. Queries marked Pending have not yet been processed. Queries marked Partially Completed require additional processing time. Queries marked Rejected have one or more errors; they have been processed and a document describing the error(s) is available for retrieval.

Entities that submit queries via the ITP must retrieve their query responses using the file transfer program specified in the ITP instructions. ITP responses are formatted in the *Interface Control Document (ICD) for Query Transactions* according to the specifications of the appropriate ICD. Subjects who self-query will receive paper responses sent by First Class U.S. Mail.

When there is no information in the NPDB about a subject, the entity receives in response to a query only the identifying subject information provided in the query and a notification that no information about the subject is contained in the NPDB. Query information submitted by the entity is not retained on subjects for whom there is no record in the NPDB.

Entities that submit 10 or fewer subject names receive separate response files for each query. When the number of subject names submitted is 11 or more, batch downloading consolidates query files so that a single file can contain multiple responses and hold up to 1 megabyte of data. Along with the query response files, entities also receive a list of all the subject names queried and the file number where each response is located. This list helps to quickly identify the location of a specific subject query response.

Query Response Availability

Query responses are available via the IQRS or ITP 4 to 6 hours after the query is processed. Entities must retrieve responses within 30 days of processing, or they will be forced to re-submit their queries. Entities that wish to save query responses should download them immediately and save them to their hard drives.

Ideally, information from the NPDB will be considered during the credentialing process. However, the NPDB law does not require querying entities to receive query responses from the NPDB before proceeding with the granting of clinical privileges, hiring, appointment to the medical staff, issuance of licenses, or approval of memberships. Because the NPDB is one of several resources for the credentials review process, entities may act on applications according to their established criteria and information obtained from other sources.

Missing Query Responses

If you do not receive a query response within 2 to 3 business days of submission, please contact the NPDB-HIPDB Customer Service Center to request a query status. Please do not resubmit a query on the subject in question, as this will result in duplicate transactions and duplicate query fees.

Correcting Query Information

If the information you submitted in a query does not accurately identify the subject on whom you intended to query, your query will not match NPDB reports submitted with correct identifying information. To query the NPDB with the proper identifying information on the subject, submit a new, correctly completed query to the NPDB.

Failure to Query

Any hospital that does not query on a practitioner (1) at the time the practitioner applies for a position on its medical staff or for clinical privileges (initial or expanded) at the hospital, and (2) every 2

years concerning any practitioner who is on its medical staff or has clinical privileges at the hospital, is presumed to have knowledge of any information reported to the NPDB concerning the practitioner. A hospital's failure to query on a practitioner may give a plaintiff's attorney or plaintiff representing himself or herself access to NPDB information on that practitioner for use in litigation against the hospital.

Questions and Answers

1. **Should I query on the members of my hospital's Allied Health Practitioner Staff?**

   If the Allied Health Practitioners are granted clinical privileges or medical staff membership, yes. For example, if your hospital grants clinical privileges to nurse practitioners, you must query on them. Each hospital must determine, based on State law and on its own by-laws, which practitioners are licensed by its State and credentialed as part of the medical staff or granted clinical privileges. The intent of the statute is to require querying on medical staff members or privilege holders who are individually credentialed by the hospital.

2. **Are hospitals required to query the NPDB on medical and dental interns and residents?**

   No. Since interns and residents are trainees in structured programs of supervised graduate medical education and are not (generally) members of the medical staff in a formal sense, there is no requirement to query on them. Hospitals may choose to query on residents and interns if they desire. However, if the resident or intern is being considered for clinical privileges outside of his or her structured program, the hospital must query. Note that medical malpractice payments made on behalf of and adverse licensure actions taken against residents and interns must be reported.

3. **Is my hospital required to query on all of our nurses?**

   If an individual belongs to the medical staff or has clinical privileges at your hospital and if that individual is licensed or otherwise authorized (either registered or certified) by a State to provide health care services, the hospital is required to query on that individual. Examples of nursing staff who frequently are granted individual privileges and meet this definition may include certified nurse anesthetists and nurse practitioners.

4. **Are hospitals required to document and maintain records of their requests for information?**

   Hospitals are not specifically required by the NPDB's implementing regulations to do so.

5. **How long should my organization keep query responses on file?**

   While the NPDB regulations require hospitals to query the NPDB, they do not specify that query responses be kept on file by requesting entities. Please note, however, that your query response may be used as proof that your organization queried the NPDB on the practitioners.

6. **If I cannot find or did not receive a response to a query, may I request a copy from the NPDB?**

   No. The NPDB currently does not have the capability to produce duplicate responses. If you did not receive a response to a query and were not charged for the query, the query has not been processed by the NPDB and should be resubmitted. Once processed by the NPDB, query responses will be maintained in the IQRS for 30 days. After 30 days, the responses will be deleted from the IQRS and the entity will have to resubmit the query to receive a response. If you did not receive a response to a query but were charged for it, see the Missing Query Responses section in this chapter of the *Guidebook*.

7. **May self-queries be used to satisfy requirements for peer review and employment?**

   Subjects may share the information contained in their own self-query responses with whomever they choose; however, such shared information **does not** satisfy a hospital's legal requirement to query the NPDB whenever a physician, dentist, or other health care practitioner applies for clinical privileges or a medical staff appointment.

8. **My hospital is in Chapter 7 bankruptcy. Can it continue to query the NPDB?**

   If your hospital still has ongoing business and is functioning as a hospital while concluding its liquidation, even under a debtor-in-possession, it must continue to query the NPDB. If it is in liquidation solely for the purpose of sale of assets and there is no ongoing business as a hospital, there is no reason to query and your DBID will be deactivated. Your organization is responsible for notifying the NPDB of your status. If the hospital comes under new ownership, the new owner must register with the NPDB and is responsible for fulfilling its reporting and querying obligations.

9. **My hospital is in Chapter 9 bankruptcy. Can it continue to query the NPDB?**

   Yes. Your hospital will be charged for any queries submitted after the NPDB receives notice of the filing of the Petition for Bankruptcy. Organizations that have an obligation to query (i.e., hospitals) must still meet their querying obligations.

10. **My hospital is in Chapter 11 bankruptcy. Can it continue to query the NPDB?**

    Yes. Your organization will be charged for any queries submitted after the NPDB receives notice of the filing of the Petition for Bankruptcy. Organizations that have an obligation to query (i.e., hospitals) must still meet their querying obligations.

11. **My hospital has been liquidated by the State. Can it continue to query the NPDB?**

    If your hospital still has ongoing business and is functioning as a hospital while concluding its liquidation, it must continue to query the NPDB. Once the liquidation process is concluded or your organization has no ongoing business as a hospital, there is no reason to query and your DBID will be deactivated. Your organization is responsible for notifying the NPDB of its status. If the hospital comes under new ownership, the new owner must register with the NPDB and is responsible for fulfilling its reporting and querying obligations.

12. **Can I designate more than one authorized agent to query for my hospital?**

    Yes. The NPDB computer system can now accommodate multiple authorized agents for each querying entity.

13. **If I decide to designate an authorized agent or change from one agent to another, how long will it take before the authorized agent can query for my hospital?**

    If the authorized agent is already registered with the NPDB and has been assigned a DBID, the NPDB will send notification documents to your organization and the authorized agent. You should check the documents to ensure that all information is correct. Your authorized agent will be able to query on your organization's behalf immediately upon receipt of the notification documents.

Overview

The NPDB acts primarily as a flagging system; its principal purpose is to facilitate a comprehensive review of professional credentials. Information on medical malpractice payments, certain adverse licensure actions, adverse clinical privilege actions, adverse professional society membership actions and Medicare/Medicaid exclusions is collected from and disseminated to eligible entities. NPDB information should be considered with other relevant information in evaluating a practitioner's credentials.

Eligible entities are responsible for meeting specific querying and/or reporting requirements and must register with the NPDB in order to query or report to the NPDB.

The information required to be reported to the NPDB is applicable to physicians, dentists, and, in some cases, other health care practitioners who are licensed or otherwise authorized by a State to provide health care services.

Time Frame for Reporting to the NPDB

Mandated NPDB reporters must report medical malpractice payments and adverse actions taken on or after September 1, 1990. This is the date that the NPDB commenced operation. With the exception of reports on Medicare/Medicaid Exclusions, the NPDB cannot accept any report with a date of payment or a date of action prior to September 1, 1990.

Civil Liability Protection

The immunity provisions in the *Healthcare Quality and Improvement Act of 1986* protect individuals, entities, and their authorized agents from being held liable in civil actions for reports made to the NPDB unless they have actual knowledge of falsity of the information. The statute provides the same immunity to HHS in maintaining the NPDB. For more information on civil liability protection, refer to page A-2.

Official Language

The NPDB's official language is English. All reports must be submitted in English. Files submitted in any other language or containing non-alphanumeric characters (e.g., tildes, accents, umlauts) are not accepted.

Computation of Time Periods

In computing any period of time prescribed or allowed by the NPDB statute or regulations, the date of the act or event in question shall not be included. The day following the date of the act or event is Day 1 for purposes of computation. The last day of the period so computed shall be included. Saturdays, Sundays, and Federal holidays are to be included in the calculation of time periods. However, if the end date for submitting a report falls on a Saturday, Sunday, or Federal holiday, the due date is the next Federal work day. This method of computation of time periods is consistent with *Federal Rule of Civil Procedure 6*.

Table E-1. NPDB Reporting Requirements

Entity	Physicians and Dentists	Other Health Care Practitioners
Medical Malpractice Payers Payment resulting from written claim or judgment. Reports must be submitted to the NPDB and appropriate State licensing board within 30 days of a payment.	Must report	Must report
State Licensing Boards Licensure disciplinary action based on reasons related to professional competence or conduct. Reports must be submitted to the NPDB within 30 days of the action.	Must report	Currently no reporting requirements
Hospitals and Other Health Care Entities Professional review action, based on reasons related to professional competence or conduct, adversely affecting clinical privileges for a period longer than 30 days; or voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation. Reports must be submitted to the NPDB and appropriate State licensing board within 15 days of the action.	Must report	May report
Professional Societies Professional review action, based on reasons relating to professional competence or conduct, adversely affecting membership. Reports must be submitted to the NPDB and appropriate State licensing board within 15 days of the action.	Must report	May report
HHS Office of Inspector General Exclusions from Medicaid/Medicare and other Federal programs. Exclusions are reported monthly.	Must report	Must report

Submitting Reports to the NPDB

Subject Information

When submitting a report to the NPDB, the reporting entity is required to provide certain subject information. **The NPDB computer system does not allow entities to submit reports that do not include information in all mandatory fields. An entity's lack of mandatory information does not relieve the entity of reporting requirements for the purposes of Title IV.** All required fields in a subject's record must be completed before a report can be generated. Entities should provide as much information as possible, even in the fields that are not required.

When Subject Information Is Unknown

As indicated previously, the NPDB computer system does not allow reports to be submitted without all mandatory subject information. The NPDB suggests that each reporting entity review the mandatory fields information and make an effort to collect this information for each practitioner before there is a cause to file a report (i.e., during the application process). An incomplete report (one that is missing required information or is improperly completed) is not accepted. If you are having trouble filing your electronic report, please contact the NPDB-HIPDB Customer Service Center.

Reporting Subject Social Security Numbers

Under Title IV, a subject's Social Security Number (SSN) should be provided if known when reporting medical malpractice payments, adverse clinical privileges and professional society actions, but only if obtained in accordance with Section 7 of the *Privacy Act of 1974*, which provides that disclosure of an individual's SSN is voluntary unless otherwise provided by law. Disclosure of an individual's SSN for the purposes of the NPDB is voluntary.

The NPDB will use SSNs only to verify the identity of individuals, and SSNs are disclosed only as authorized by the *Health Care Quality Improvement Act of 1986*, as amended. The inclusion of this information, wherever possible, is encouraged because it helps to ensure the accurate identification of the subject of the report.

An SSN is required for adverse licensure actions, as these reports are also mandated for inclusion in the HIPDB under Section 1128E of the *Social Security Act*. Section 1128E requires that SSNs be provided as part of the reporting process.

Incorrectly Identified Subject

If an entity reports information for the wrong subject, the reporting entity must submit a Void of the incorrect report and submit a new Initial report for the correct subject. See page E-5 for more information on Void reports.

Submitting Reports Via the IQRS

Eligible entities may prepare and submit reports using the IQRS at *www.npdb-hipdb.com*. Once logged onto the site, the entity may enter and submit report information to the NPDB.

Medical malpractice payments are submitted using the Medical Malpractice Payment Report (MMPR) format. Clinical privileges, professional society and licensure actions, as well as Medicare/Medicaid exclusions are submitted using the Adverse Action Report (AAR) format.

Both the MMPR and the AAR formats in the IQRS capture all the necessary information for report submission. Sufficient space is provided in the fields to allow entry of multiple practitioner license numbers, Federal Drug Enforcement Administration (DEA) numbers, professional schools, and hospital affiliations. The IQRS allows for a 2,000-character description of the acts or omissions and, in the case of MMPRs, a description of the judgment or settlement statements.

Subject information does not need to be reentered into a report format if an entity maintains a subject database on the IQRS. The IQRS retrieves all pertinent information from the entity's subject database into the appropriate report screens; however, if a record in the subject database is incomplete (i.e., information is missing in required fields), the IQRS does not allow a report to be generated for that subject until the missing information is added. For more information on subject databases, see the *Fact Sheet on Creating and Maintaining a Subject Database*, available at *www.npdb-hipdb.com*.

Each data field on the report input screens is limited to a certain number of characters, including spaces and

punctuation. For example, the narrative description fields allow 2,000 characters, including spaces and punctuation. Any characters over 2,000 are truncated. Drafting your narrative in accordance with the character limits will avoid the need to correct a truncated narrative once the report is accepted by the NPDB.

Upon submitting the report to the NPDB, the entity will receive a *Temporary Record of Submission* document with a confirmation number. The confirmation number can be used to verify that the entity submitted the report. Within 4 to 6 hours of receipt, the NPDB will make available to the reporting entity an official *Report Verification Document*. The reporting entity must verify the report data on the *Report Verification Document* and correct any erroneous information on-line. The subject of the report will receive a copy of the submitted report by mail from the NPDB. Each NPDB reporter must mail a copy of the paper report to the appropriate State licensing board.

Draft Capability

The IQRS includes a Draft report feature for entering report data into input screens, then saving the document in draft status. The draft version of a report can be modified later. Draft reports may be saved on the IQRS server for a maximum of 30 days before they are automatically deleted. Reports saved as drafts are not considered official report submissions. Draft reports must be completed, submitted, and successfully processed by the NPDB to fulfill Title IV reporting requirements.

Submitting Reports to the NPDB Via ITP

If a reporting entity does not have access to the IQRS, or prefers to generate reports using custom software, the entity may choose to submit reports via an electronic transaction file submission (known as ICD Transfer Program [ITP]). This method of reporting requires the entity to submit data using a format specified by the NPDB. Interface Control Documents (ICDs) specify the format for ITP report submissions of MMPRs and AARs. These documents are available at *www.npdb-hipdb.com*. See page D-6 for an explanation of ITP.

Types of Reports

Initial Report

The first record of a medical malpractice payment or adverse action submitted to and processed by the NPDB is considered the Initial report. An Initial report is the current version of the report until a Correction, Void, or Revision to Action is submitted.

When the NPDB processes an Initial report, a *Temporary Record of Submission* document is available to print or save until the official *Report Verification Document* is retrieved by the reporting entity from the IQRS. A *Notification of a Report in the NPDB-HIPDB* is mailed to the subject. The reporting entity and the subject should review the report information to ensure that it is correct. The reporting entity should also print and mail a copy of the Initial report to the appropriate State licensing board.

Correction

A Correction is a change intended to supersede the contents of the current version of a report. The reporting entity must submit a Correction as soon as possible after the discovery of an error or omission in a report. A Correction may be submitted to replace the current version of a report as often as necessary.

When the NPDB processes a Correction, a *Temporary Record of Submission* document is available to print or save until the official *Report Verification Document* is retrieved from the IQRS. A *Report Revised, Voided, or Status Changed* document is mailed to the subject and all queriers who received the previous version of the report within the past 3 years. The reporting entity and the subject should review the information to ensure that it is correct, and queriers should note the changed report. The reporting entity should also print and mail a copy of the Correction to the appropriate State licensing board.

Example: A hospital submits a clinical privileges action to the NPDB. Upon receiving the Report Verification Document, the hospital identifies an error in the subject's address. The hospital submits a Correction to the Initial Report, including the correct address.

Void Previous Report

A Void is the retraction of a report in its entirety. An example of a Void is the reversal of a professional review action. The report is removed from the subject's disclosable record. A Void may be submitted by the reporting entity at any time.

When the NPDB processes a Void, a *Temporary Record of Submission* is available to print or save until the official void verification is retrieved from the IQRS. A *Report Revised, Voided, or Status Changed* document is mailed to the subject and all queriers who received the previous version of the report within the past 3 years. The reporting entity and the practitioner should review the information to ensure that the correct report was voided, and queriers should note that the report was voided. The reporting entity should also print and mail a copy of the Void to the appropriate State licensing board.

Example: A State Medical Board submits an AAR when it revokes a physician's license. Six months later, the revocation is overturned by a State court. The State Medical Board should submit a Void of the Initial Report.

Revision to Action

A Revision to Action reports an action that relates to and/or modifies an adverse action previously reported to the NPDB. It is treated as a second and separate action by the NPDB, but it does not negate the original action that was taken. The entity that reports on initial adverse action must also report any revision to that action.

A Revision to Action report should be submitted for the following reasons:

- Additional sanctions have been taken against the subject based on a previously reported incident.
- The length of action has been extended or reduced.

- The original suspension or probationary period has ended.
- Licensure, clinical privileges, professional society membership, or program participation has been reinstated.

A Revision to Action should not be reported unless the initial action was reported to the NPDB. When submitting a Revision to Action, the reporter must reference the Data Bank Control Number (DCN) on the report of the action being modified.

A Revision to Action is separate and distinct from a Correction. For example, if the hospital in the above example enters the Date of Action incorrectly, a Correction must be submitted to make the necessary change, and the Correction overwrites the Initial report. A Revision to Action is treated as an addendum to the Initial report.

When the NPDB processes a Revision to Action, a *Temporary Record of Submission* document is available to print or save until the official *Report Verification Document* is retrieved from the IQRS. A *Notification of a Report in the NPDB* is mailed to the subject practitioner. The reporting entity and the practitioner should review the information to ensure that it is correct. The reporting entity should also print and mail a copy of the Revision to Action to the appropriate State licensing board.

Example: A hospital submits an AAR when it suspends a practitioner's clinical privileges for 90 days. The suspension is later reduced to 45 days. Since this is a new action that modifies a previously reported action, the hospital must submit a new report using the Revision to Action option in the IQRS. The Initial report documents that the hospital suspended the subject's clinical privileges, and the Revision to Action documents that the hospital made a subsequent revision to the action.

Example: A hospital submits an AAR when it revokes an oral surgeon's clinical privileges. Two years later, the oral surgeon's clinical privileges are reinstated. Since this action modifies the original action, the hospital must submit a Revision to Action. The Initial report documents that the hospital revoked the oral surgeon's clinical privileges, and the Revision to Action documents that the hospital made a revision to the action.

Report Processing

When the NPDB receives a report, the information is entered into the NPDB computer system. Each version of a report processed by the NPDB computer system is assigned a unique DCN. This number is used to locate the report within the NPDB computer system. The DCN is prominently displayed in the electronic *Report Verification Document*. The DCN assigned to the most current version of the report must always be referenced in any subsequent action involving the report.

Report Responses

Each time a report is successfully submitted to the IQRS and processed by the NPDB, a *Report Verification Document* is stored for the reporting entity to retrieve through the IQRS. Reports are generally processed within 4 to 6 hours of

receipt. Once viewed, the report output is maintained on the server for 30 days before it is automatically deleted.

Entities should print or save the report output before automatic deletion occurs.

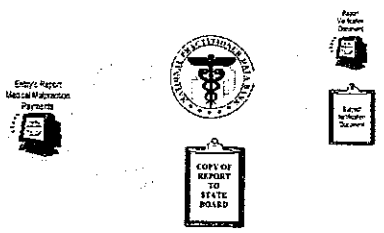
Entities that submit reports via the ITP must retrieve their report responses using the file transfer program specified in the ITP instructions. ITP responses are formatted according to the specifications of the appropriate ICD. As with responses downloaded from the IQRS, entities must review their report verifications to ensure that the information is correct and that copies of the reports are mailed to the appropriate State licensing boards.

Missing Report Verification

Reports will be available electronically within an average of 4 to 6 hours of receipt by the NPDB. Under certain circumstances, additional processing may be required. Entities should not re-submit reports on the subject in question, since this will result in duplicate reports. If you do not receive your response within 2 to 3 business days of submission, please call the NPDB-HIPDB Customer Service Center.

If your original report is not processed, the NPDB will require a new report. The NPDB will process the report and provide you with a DCN. If you need to make a change to the report, use the DCN and the appropriate procedures explained in this *Guidebook* to submit a Correction or a Void.

REPORTING MEDICAL MALPRACTICE PAYMENTS



Reporting Medical Malpractice Payments

Each entity that makes a payment for the benefit of a physician, dentist, or other health care practitioner in settlement of, or in satisfaction in whole or in part of, a claim or judgment against that practitioner must report the payment information to the NPDB. A payment made as a result of a suit or claim solely against an entity (for example, a hospital, clinic, or group practice) and that does not identify an individual practitioner is not reportable under the NPDB's current regulations.

Eligible entities must report when a lump sum payment is made or when the first of multiple payments is made. Medical malpractice payments are limited to exchanges of money and must be the result of a written complaint or claim demanding monetary payment for damages. The written complaint or claim must be based on a practitioner's provision of or failure to provide health care services. A written complaint or claim can include, but is not limited to, the filing of a cause of action based on the law of tort in any State or Federal court or other adjudicative body, such as a claims arbitration board.

Trigger Date for Reporting

Reports must be submitted to the NPDB and the appropriate State licensing boards within 30 days of the date that a payment is made (the date of the payment check). The report must be submitted regardless of how the matter was settled (for instance, court judgment, out-of-court settlement, or arbitration). The 30-day period commences on the day following the date of payment.

Interpretation of Medical Malpractice Payment Information

As stated in 427(d) of the *Health Care Quality Improvement Act of 1986*, as amended (Title IV of Public Law 99-660), and in 60.7(d) of the NPDB regulations, "[A] payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred."

The Secretary of HHS understands that some medical malpractice claims (particularly those referred to as nuisance claims) may be settled for convenience, not as a reflection on the professional competence or professional conduct of a practitioner.

Reporting entities should provide a detailed narrative to describe the acts or omissions and injuries or illnesses upon which the medical malpractice action or claim was based. This narrative may be a maximum of 2,000 characters including spaces and punctuation. Any characters over 2,000 are truncated.

Narrative descriptions should include eight general categories of information: age, sex, patient type, initial event (medical condition of the patient), procedure performed, claimant's allegation, associated legal and other issues, and outcome. Narratives cannot contain patient names or names of other health care practitioners, plaintiffs, witnesses, or any other individuals involved in the case. Guidelines for these categories follow:

- **Age** – age of claimant at the time of the initial event; age is expressed in years if the claimant is 1 year of age or older, in months from 1 month through 11 months; and in days if the claimant is less than 1 month of age. Unknown may be used if applicable.
- **Sex** – male, female, and disputed; disputed may be used in claims involving individuals whose sex has been physically altered or who are physically one sex but live outwardly as the other.
- **Patient Type** – generally an indication of inpatient or outpatient status; choose inpatient, outpatient, or both.
- **Initial Event (Medical Condition of the Patient)** – choose the words that best describe the diagnosis with which the claimant presented for treatment. To report the diagnosis, the reporters should use the actual condition from which the patient suffered. When the patient has more than one condition, the reporter should use the condition that is most applicable to the generation of the claim.
- **Procedure Performed** – the treatment rendered by the insured to the patient for the medical condition described under "Medical Condition of the Patient." If more than one procedure was used, the procedure that is most significant to the claim's generation should be used.
- **Claimant's Allegation** – the occurrence that precipitated the claim of medical and/or legal damages; the time sequence in relation to the initial event is relevant.
- **Associated Legal and Other Issues** – any associated issues that have an impact on the claim.
- **Outcome** – a description of the outcome resulting from the initial event and the claimant's allegation.

Sample Descriptions for Illustrative Purposes Only:

A 65-year-old male outpatient had a prostate exam by Dr. A. Six months later, the patient was diagnosed by Dr. B with

prostate cancer and underwent surgery. One year later, the patient sued Dr. A for alleged failure to diagnose. A settlement was reached in the amount of $250,000.

A 57-year-old female outpatient had a mammogram. One year later, the patient was diagnosed with breast cancer and she underwent chemotherapy and radiation. The patient sues the physician for alleged failure to diagnose and treat. A settlement was reached in the amount of $100,000.

A 45-year-old male came to the emergency department with complaints of shoulder and chest pain, and he was discharged after evaluation. Six hours later, he had a cardiac arrest and could not be resuscitated. The estate sued the treating emergency room physician for alleged failure to diagnose and treat. The case went to trial and resulted in a verdict in favor of the plaintiff for $1,000,000.

A 9-month-old girl was seen in a private office with fever and treated symptomatically. The next day she was brought to the hospital in convulsions. Her parents allege that a delay in the diagnosis of meningitis caused permanent neurological damage. A settlement was reached in the amount of $2,000,000.

A 31-year-old pregnant woman was admitted to the hospital by her physician in the early stages of labor. After four hours, the woman began to show signs of fetal distress. The hospital staff attempted to contact the physician but could not locate her for four hours. The patient sued the physician, alleging that the physician's abandonment caused permanent neurological damage to the child. A settlement was reached in the amount of $2,000,000.

(Portions adopted from the Harvard Risk Management Foundation Sample Claims Descriptions.)

Reporting of Payments by Individuals

Individual subjects are not required to report payments they make for their own benefit to the NPDB. On August 27, 1993, the Circuit Court of Appeals for the District of Columbia held that [445 (DC Cir. 3 F.3D 1993)] the NPDB regulation requiring each "person or entity" that makes a medical malpractice payment was invalid, insofar as it required individuals to report such payments. The NPDB removed reports previously filed on medical malpractice payments made by individuals for their own benefit.

A professional corporation or other business entity comprised of a sole practitioner that makes a payment for the benefit of a named practitioner must report that payment to the NPDB. However, if a practitioner or other person, rather than a professional corporation or other business entity, makes a medical malpractice payment out of personal funds, the payment is not reportable.

Payments for Corporations and Hospitals

Medical malpractice payments made solely for the benefit of a corporation such as a clinic, group practice, or hospital are currently not reportable to the NPDB. A payment made for the benefit of a professional corporation or other business entity that is comprised of a sole practitioner is reportable if the payment was made by the entity rather than by the sole practitioner out of personal funds.

Deceased Practitioners

One of the principal objectives of the NPDB is to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of their previous damaging or incompetent performance. The NPDB requires reporting medical malpractice payments made for the benefit of deceased practitioners (or for their benefit through their estates) because a fraudulent practitioner could assume the identity of a deceased practitioner.

When submitting an MMPR for a deceased practitioner, check the deceased block on the appropriate MMPR screen in the IQRS. The NPDB makes an electronic report verification available to the reporting entity via the IQRS.

Identifying Practitioners

In order for a particular physician, dentist, or other health care practitioner to be named in an MMPR submitted to the NPDB, the practitioner must be named in both the written complaint or claim demanding monetary payment for damages and the settlement release or final adjudication, if any. Practitioners named in the release, but not in the written demand or as defendants in the lawsuit, are not reportable to the NPDB. A practitioner named in the written complaint or claim who is subsequently dismissed from the lawsuit and not named in the settlement release is not reportable to the NPDB. In some States, the given name of the practitioner does not have to appear in the release or final adjudication as long as the practitioner is sufficiently described in the settlement or final adjudication as to be identifiable. In those States, an NPDB report on the practitioner named in the complaint, but not in the release or final adjudication, is required as long as he or she is sufficiently described as to be individually identifiable.

Insurance Policies that Cover More than One Practitioner

A medical malpractice payment made under an insurance policy that covers more than one practitioner should only be reported for the individual subject for whose benefit the payment was made, not for every practitioner named on the policy.

One Settlement for More than One Practitioner

In the case of a payment made for the benefit of multiple practitioners, wherein it is impossible to determine the amount paid for the benefit of each individual practitioner, the insurer must report, for each practitioner, the total (undivided) amount of the initial payment and the total number of practitioners on whose behalf the payment was made. In the case of a payment made for the benefit of multiple practitioners where it is possible to apportion payment amounts to individual practitioners, the insurer must report, for each practitioner, the actual amount paid for the benefit of that practitioner.

Residents and Interns

Reports must be submitted to the NPDB when medical malpractice payments are made for the benefit of licensed residents or interns. Medical malpractice payments made for the benefit of housestaff insured by their employers are also reportable to the NPDB.

Students

Payments made for the benefit of medical or dental students are not reportable to the NPDB. Unlicensed student providers provide health care services exclusively under the supervision of licensed health care professionals in a training environment. Students do not fall into the "other health care practitioner category;" other health care practitioners are licensed by a State and/or meet State registration or certification requirements.

Practitioner Fee Refunds

If a refund of a practitioner's fee is made by an entity (including solo incorporated practitioners), that payment is reportable to the NPDB. A refund made by an individual is not reportable to the NPDB.

For purposes of NPDB reporting, medical malpractice payments are limited to exchanges of money. A refund of a fee is reportable only if it results from a written complaint or claim demanding monetary payment for damages. The written complaint or claim must be based on a physician's, dentist's, or other health care practitioner's provision of, or failure to provide, health care services. A written complaint or claim may include, but is not limited to, the filing of a cause of action based on the law of tort in any State or Federal court or other adjudicative body, such as a claims arbitration board.

A waiver of a debt is not considered a payment and should not be reported to the NPDB. For example, if a patient has an adverse reaction to an injection and is willing to accept a waiver of fee as settlement, that waiver is not reportable to the NPDB.

Loss Adjustment Expenses

Loss adjustment expenses (LAEs) refer to expenses other than those in compensation of injuries, such as attorney's fees, billable hours, copying, expert witness fees, and deposition and transcript costs. If LAEs are not included in the medical malpractice payment amount, they are not required to be reported to the NPDB.

LAEs should be reported to the NPDB only if they are included in a medical malpractice payment. Reporting requirements specify that the total amount of a medical malpractice payment and a description and amount of the judgment or settlement and any conditions, including terms of payment should be reported to the NPDB. LAEs should be itemized in the description section of the report form.

Dismissal of a Defendant from a Lawsuit

A payment made to settle a medical malpractice claim or action is not reportable to the NPDB if the defendant health care practitioner is dismissed from the lawsuit prior to the settlement or judgment. However, if the dismissal results from a condition in the settlement or release, then the payment is reportable. In the first instance, there is no payment for the benefit of the health care practitioner because the individual has been dismissed from the action independently of the settlement or release. In the latter instance, if the practitioner is dismissed from the lawsuit in consideration of the payment being made in settlement of the lawsuit, the payment can only be construed as a payment for the benefit of the health care

practitioner and must be reported to the NPDB.

Example: A health care practitioner is named in a lawsuit. The practitioner agrees to a payment on the condition that his or her name does not appear in the settlement. The payment would be reportable to the NPDB.

High-Low Agreements

A "high-low" agreement, a contractual agreement between a plaintiff and a defendant's insurer, defines the parameters of a payment the plaintiff may receive after a trial or arbitration proceeding. If the finder of fact returns a defense verdict, the defendant's insurer agrees to pay the "low end" amount to the plaintiff. If the finder of fact returns a verdict for the plaintiff and against the defendant, the defendant's insurer agrees to pay the "high end" amount to the plaintiff.

A payment made at the low end of a high/low agreement that is in place prior to a verdict or an arbitration decision would not be reportable to the NPDB only if the fact-finder rules in favor of the defendant and assigns no liability to the defendant practitioner. In this case, the payment is not being made for the benefit of the practitioner in settlement of a medical malpractice claim. Rather, it is being made pursuant to an independent contract between the defendant's insurer and the plaintiff. The benefit to the insurer is the limitation on its liability, even if the plaintiff wins at trial and is awarded a higher amount. The benefit to the plaintiff is a guaranteed payment, even if there is no finding of liability against the practitioner. *Note: in order for the low-end payment to be exempted from the reporting requirements, the fact finder must have made a determination regarding liability at the trial or arbitration proceeding.*

A payment made at the high end of the agreement is one made for the benefit of the practitioner and, therefore, must be reported to the NPDB. When a defendant practitioner has been found to be liable by a fact-finding authority, such as a judge, a jury, or by arbitration, any payment made pursuant to that finding must be reported, regardless of the existence of a high-low agreement.

If a high-low agreement is in place, and the plaintiff and defendant settle the case prior to trial, the existence of the high-low agreement does not alter the reportability of the settlement payment.

Example 1: A high-low agreement is in place prior to trial. The parties agree to a low end payment of $25,000 and a high end payment of $100,000. The jury finds the defendant physician liable and awards $20,000 to the plaintiff in damages. This $20,000 payment is reportable because the jury found the defendant physician liable.

Example 2: A high-low agreement is in place prior to binding arbitration. The parties agree to a low end payment of $50,000 and a high end payment of $150,000. The arbitrator finds in favor of the defendant practitioner. However, due to the existence of the high-low agreement, the defendant's insurer makes a payment of $50,000 to the plaintiff (the low end payment). This payment is not reportable since it is being made pursuant to an independent contract between the defendant's insurer and the plaintiff.

Example 3: A high-low agreement is in place prior to trial. The parties agree to a low-end payment of $50,000 and a high end payment of $150,000. Before the fact finder returns a verdict, the parties settle the case for $50,000. This payment is reportable because it is made in settlement of the claim.

Example 4: A high-low agreement is in place prior to trial. The parties agree to a low-end payment of $50,000 and a high-end payment of $100,000. Rather than go to trial, the parties agree to binding arbitration to assess the amount of damages the plaintiff will receive. The arbitrator awards the plaintiff $50,000. In this case, the arbitration was conducted to determine the amount of recovery by the plaintiff, not whether or not the plaintiff will recover. Because no liability was to be determined at this arbitration proceeding, the payment is made in settlement of the claim and is reportable.

Reporting by Authorized Agents

The organization that makes the medical malpractice payment is the organization that must report medical malpractice payments to the NPDB.

A medical malpractice payer may choose to use an adjusting company, claims servicing company, or law firm, acting as its authorized agent to complete and submit NPDB reports. An insurance company may also wish to have all of its NPDB correspondence related to reports handled by an authorized agent. This is strictly a matter of administrative policy by the medical malpractice payer. When reporting a payment, the reporting entity information in the MMPR must be completed using the name, address, and DBID of the organization that made the payment.

For information on registering an authorized agent or designating one, see pages B-7 and B-8, respectively.

Payments by Multiple Payers

Any medical malpractice payer that makes an indemnity payment for the benefit of a practitioner must submit a report to the NPDB. Generally, primary insurers and excess insurers are obligated to make an indemnity payment for the benefit of a practitioner and so must submit a report to the NPDB. Typically, reinsurers are obligated to make an indemnity payment directly to the primary insurer, not for the benefit of the practitioner, and are not required to submit a report to the NPDB.

For example, if three primary insurers contribute to a payment, all three insurers are required to submit separate MMPRs to the NPDB. Each insurer should describe the basis for their payment in the narrative description of the settlement to avoid the impression of duplicate reporting.

Structured Settlements

A medical malpractice payer entering into a structured settlement agreement with a life insurance or annuity company must submit a payment report within 30 days after the lump sum payment is made by the payer to that company.

Payments made after the opening of the NPDB (September 1, 1990) under annuities existing prior to the NPDB opening are not reportable to the NPDB.

Subrogation-Type Payments

Subrogation-type payments made by one insurer to another are not required to be reported, provided that the insurer receiving the payment has previously reported the total judgment or settlement to the NPDB. Subrogation often occurs when there is a dispute between insurance companies over whose professional liability policy ought to respond to a lawsuit.

Example: A practitioner is insured in 1991 by Insurer X and changes over to Insurer Y in 1992. Both policies provide occurrence-type coverage. A medical malpractice lawsuit is filed in 1992. There is a dispute over whether the alleged medical malpractice occurred in late 1991 or early 1992. Under the 1992 policy, Insurer Y agrees to defend the lawsuit but obtains an agreement from the practitioner that it may pursue the practitioner's legal right to recover any indemnity and defense payments that should have been paid under Insurer X's policy. This is a subrogation agreement. The jury subsequently determines that the incident occurred in 1991 and awards $500,000 to the plaintiff. Insurer Y makes the $500,000 payment to the plaintiff and reports it to the NPDB. Insurer Y seeks subrogation of its indemnity and defense payments from Insurer X. Insurer X ultimately concedes and pays Insurer Y the $500,000 plus defense costs. Insurer X is not required to report its reimbursement of Insurer Y to the NPDB.

Offshore Payers

A medical malpractice payment made by an offshore medical malpractice insurer must be reported to the NPDB. An offshore insurer with an agent in the United States is subject to service (which means that it can be served with a Federal complaint); therefore, the reporting requirement can be enforced. It is not the NPDB's responsibility to identify these companies; rather, it is the responsibility of these companies to comply with the statute and register with the NPDB.

Payments Made Prior to Settlement

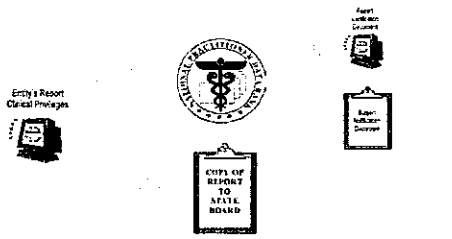
When a payment is made prior to a settlement or judgment, a report must be submitted within 30 days from the date the payment was made. Since the total amount of the payment is unknown, the medical malpractice payer should state this in the narrative description section of the report. When the settlement or judgment is finalized, the insurer must submit a Correction to the Initial Report.

When reporting medical malpractice payment information, please be aware that leaving the Payment Result reason and Date of Judgment or Settlement fields on the MMPR format blank indicates that the payment was made prior to a judgment or settlement. When a payment is made as a result of a judgment or settlement, these fields should be properly completed. Likewise, the Adjudicative Body Case Number, Adjudicative Body Name, and Court File Number fields should be left blank only when there was not a filing with an adjudicative body. See Table E-2 on page E-16 for information on determining reportable medical malpractice payments.

Table E-2. Determining Reportable Medical Malpractice Payments

Action	NPDB Reporting Responsibility
A malpractice settlement or court judgment includes stipulation that the terms are kept confidential	Must file report.
Malpractice settlement is structured so that claimant receives an annual sum for each year he or she is alive.	Report the initial payment after NPDB opening; identify as multiple payments.
Malpractice settlement involves five practitioners.	Must file a separate report on each of the five practitioners.
Payment is made based only on oral demands.	No report is required.
Payment made by an individual.	A professional corporation or other business entity comprised of sole practitioner must file a report. No report is required for an individual making payment out of personal funds.
Payments made for corporations and hospitals.	Payments made for the benefit of a corporation such as a clinic group practice or hospital are not currently reportable. Payment is reportable when made for business entities comprised of sole practitioners.
Payments made for licensed residents and interns.	Must file report.
Practitioner fee refund.	Must file report if refund is made by an entity (including solo incorporated practitioners). No report is required if refund is made by an individual.
Dismissal of defendant from lawsuit.	No report required if defendant is dismissed prior to settlement or judgment. Report is required if dismissal results from condition in settlement or release.

REPORTING ADVERSE CLINICAL PRIVILEGES ACTIONS



Reporting Adverse Clinical Privileges Actions

Health care entities must report adverse actions within 15 days from the date the adverse action was taken or clinical privileges were voluntarily surrendered. **The health care entity must print a copy of each report submitted to the NPDB and mail it to the appropriate State licensing board for its use.** The *Report Verification Document* that health care entities receive after a report is successfully processed by the NPDB should be used for submission to the appropriate State licensing board.

Reportable adverse clinical privileges actions are **based on a physician's or dentist's professional competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of a patient.** Hospitals and other eligible health care entities must report:

- Professional review actions that adversely affect a physician's or dentist's clinical privileges for a period of more than 30 days.
- Acceptance of a physician's or dentist's surrender or restriction of clinical privileges while under investigation for possible professional incompetence or improper professional conduct or in return for not conducting an investigation or reportable professional review action.

Adverse actions taken against a physician's or dentist's clinical privileges include reducing, restricting, suspending, revoking, or denying privileges, and also include a health care entity's decision not to renew a physician's or dentist's privileges if that decision was based on the practitioner's professional competence or professional conduct. **Health care entities may report such actions taken against the clinical privileges of other health care practitioners.**

Adverse actions involving censures, reprimands, or admonishments should not be reported to the NPDB. Matters not related to the professional competence or professional conduct of a practitioner should not be reported to the NPDB. For example, adverse actions based primarily on a practitioner's advertising practices, fee structure, salary arrangement, affiliation with other associations or health care professionals, or other competitive acts intended to solicit or retain business are excluded from NPDB reporting requirements.

See Table E-3 on page E-21 for more information on determining reportable actions for clinical privileges.

Hospitals and other health care entities must report revisions to previously reported adverse actions. For more information on revisions, see page E-5, Revision to Action, in the Types of Reports section.

Multiple Adverse Actions

If a single professional review action produces multiple clinical privileges actions (for example, a 12-month suspension followed by a 5-month probation), only one report should be submitted to the NPDB. The Adverse Action Classification Code for the principal action should be submitted on the AAR, and the narrative description should describe the additional adverse actions imposed.

A Revision to Action must be submitted when each of the multiple actions is lifted. (Following the previous example, a revision must be submitted when clinical privileges are reinstated with probation after the suspension, and another revision must be submitted when the probationary period ends.)

If an adverse action against the clinical privileges of a practitioner is based on multiple grounds, only a single report must be submitted to the NPDB. However, all reasons for the action should be reported and explained in the narrative. The reporting entity may select up to four Basis for Action codes to indicate these multiple reasons. Additional reasons should be summarized in the narrative description.

Denial of Applications

A restriction or denial of clinical privileges that occurs solely because a practitioner does not meet a health care institution's established threshold eligibility criteria for that particular privilege is not reportable to the NPDB.

Such restrictions or denials are not deemed the result of a professional review action relating to the practitioner's professional competence or professional conduct, but are considered decisions based on eligibility.

For example, if an institution retroactively changes the eligibility criteria for a particular clinical privilege, a physician that does not meet the new criteria will lose previously granted clinical privileges; this loss of privileges is not reportable to the NPDB.

Adverse clinical privileges actions reportable to the NPDB result from professional review actions relating to the practitioner's professional competence or professional conduct.

Withdrawal of Applications

Voluntary withdrawal of an initial application for medical staff appointment or clinical privileges prior to a final professional review action generally is not reportable to the NPDB. However, if a practitioner applies for renewal of medical staff appointment or clinical privileges and voluntarily withdraws that application while under investigation by the health care entity for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or taking a professional review action, then the withdrawal of application for clinical privileges is reportable to the NPDB.

Investigations

Investigations should not be reported to the NPDB; only the **surrender or restriction of clinical privileges** while under investigation or to avoid investigation is reportable. This would include a failure to renew clinical privileges while under investigation.

A health care entity that submits an AAR based on surrender or restriction of a physician's or dentist's privileges while under investigation should have contemporaneous evidence of an ongoing investigation at the time of surrender, or evidence of a plea bargain. The reporting entity should be able to produce evidence that an investigation was initiated prior to the surrender of clinical privileges by a practitioner. Examples of acceptable evidence may include minutes or excerpts from committee meetings, orders from hospital officials directing an investigation, and notices to practitioners of an investigation.

Guidelines for Investigations

- An investigation must be carried out by the health care entity, not an individual on the staff.
- The investigation must be focused on the practitioner in question.
- The investigation must concern the professional competence and/or professional conduct of the practitioner in question.
- A routine or general review of cases is not an investigation.
- A routine review of a particular practitioner is not an investigation.
- An investigation should be the precursor to a professional review action.
- An investigation is considered ongoing until the health care entity's decision making authority takes a final action or formally closes the investigation.

Summary Suspension

A summary suspension is reportable if it is:

- In effect or imposed for more than 30 days.
- Based on the professional competence or professional conduct of the physician, dentist, or other health care practitioner that adversely affects, or could adversely affect, the health or welfare of a patient.
- The result of a professional review action taken by a hospital or other health care entity.

A summary suspension is often imposed by an individual, for instance, the chairman of a department. Commonly,

this action is then reviewed and confirmed by a hospital committee, such as a medical executive committee, as authorized by the medical staff bylaws. The suspension would then be viewed as a professional review action taken by the entity.

If the suspension is modified or revised as part of a final decision by the governing board or similar body, the health care entity must then submit a Revision to Action of the Initial report made to the NPDB.

If the physician, dentist, or other health care practitioner surrenders his or her clinical privileges during a summary suspension, that action must be reported to the NPDB. The action is reportable because the practitioner is surrendering the privileges either while under investigation concerning professional conduct or professional competence that did or could affect the health or welfare of a patient or in order to avoid a professional review action concerning the same.

Summary suspensions are considered to be final when they become professional review actions through action of the authorized hospital committee or body, according to the hospital bylaws.

The basis for this interpretation is that, pursuant to Part A of the *Health Care Quality Improvement Act* (42 U.S.C. §11112)(c)(2), a summary suspension is taken to prevent "imminent danger to the health of any individual."

The Act itself treats summary suspensions differently than other professional review actions: the procedural rights of the practitioner are provided for following the suspension, rather than preceding it. This reporting policy for summary suspensions is in keeping with the purpose of the Act, which is to protect the public from the threat of incompetent practitioners continuing to practice without disclosure or discovery of previous damaging or incompetent performance.

In establishing this policy on the reporting of summary suspensions, HHS assumes that hospitals use summary suspensions for the purpose stated in Part A of the Act: to protect patients from imminent danger, rather than for reasons that warrant routine professional review actions. HHS also emphasizes that this policy on summary suspension is solely for the purpose of reporting to the NPDB, and does not relate to the criteria for immunity under Part A of the Act.

Table E-3. Determining Reportable Actions for Clinical Privileges

Action	Reportable
Based on assessment of professional competence, a proctor is assigned to a physician or dentist for a period of more than 30 days. The practitioner must be granted approval before certain medical care is administered.	Yes
Based on assessment of professional competence, a proctor is assigned to supervise a physician or dentist, but the proctor does not grant approval before medical care is provided by the practitioner.	No
As a matter of routine hospital policy, a proctor is assigned to a physician or dentist recently granted clinical privileges.	No
A physician or dentist voluntarily restricts or surrenders clinical privileges for personal reasons; professional competence or professional conduct is not under investigation.	No
A physician or dentist voluntarily restricts or surrenders clinical privileges; professional competence or professional conduct is under investigation.	Yes
A physician or dentist voluntarily restricts or surrenders clinical privileges in return for not conducting an investigation of professional competence or professional conduct.	Yes
A physician's or dentist's application for medical staff appointment is denied based on professional competence or professional conduct.	Yes
A physician or dentist is denied medical staff appointment or clinical privileges because the health care entity has too many specialists in the practitioner's discipline.	No
A physician's or dentist's clinical privileges are suspended for administrative reasons not related to professional competence or professional conduct.	No
A physician's or dentist's request for clinical privileges is denied or restricted based upon assessment of clinical competence as defined by the hospital.	Yes

Examples of Reportable and Non-Reportable Actions

Example 1: A physician member of a hospital medical staff wishes to perform several clinical tests and procedures, but does not have the appropriate clinical privileges. The physician applies for an expansion of clinical privileges. The physician's Department Head and the Medical Staff Credentials Committee find that, based on their assessment of the physician's demonstrated professional performance, the physician does not have the clinical competence to perform the additional tests and procedures, and they recommend denial of the request for expanded clinical privileges. The hospital's governing body reviews the case, affirms the findings and recommendations, and denies the physician's request for expanded clinical privileges for reasons relating to professional competence.

The action is reportable because the denial of privileges adversely affects the clinical privileges of the physician for longer than 30 days.

Whether particular actions are reportable to the NPDB is often best determined by examining a hospital's medical staff bylaws, rules, and regulations with regard to provisions defining who is empowered to take a professional review action, what constitutes a professional review action that adversely affects the clinical privileges of a practitioner, and how that action relates to professional competence or professional conduct.

Example 2: A 30-day suspension is imposed as a result of a professional review action based on a physician's professional competence.

The action is not reportable because the adverse action taken by the professional review body did not last for more than 30 days.

Example 3: A hospital reviews a surgeon's professional competence and assigns a surgical proctor for 60 days. The surgeon cannot perform surgery without being granted approval by the surgical proctor.

Since the surgeon cannot practice surgery without approval from another surgeon, this restriction of clinical privileges is reportable.

Example 4: A 31-day suspension is imposed on a physician for failure to complete medical records.

Such a suspension would be reportable to the NPDB if the failure to complete medical records related to the physician's professional competence or conduct and adversely affects or could adversely affect a patient's health or welfare.

Example 5: A physician's application for surgical privileges is denied because the physician is not board certified in the particular clinical specialty or subspecialty.

The action is not reportable if the physician fails to meet the hospital's initial credentialing criteria applied to all medical staff or clinical privilege applicants. Examples of initial criteria may include: (1) minimum professional liability coverage, (2) board certification, (3) geographic proximity to the hospital, and (4) failure to have performed the minimum number of procedures prescribed for a particular clinical privilege.

Example 6: The hospital CEO summarily suspends a physician's privileges for failure to respond to an emergency department call.

The action is reportable if the suspension continues for longer than 30 days and the hospital bylaws state that summary suspension decisions by the medical executive committee are considered to be professional review actions. A CEO may be considered a committee assisting the governing body in a professional review activity. If this is the case and the physician has been summarily suspended, the hospital medical staff bylaws will usually provide for an appeal to the medical executive committee within a few days of the CEO's decision.

Example 7: A hospital's professional review body terminates a provider-based physician contract for causes relating to poor patient care, which in turn results in loss of privileges with no right to a hearing as provided in the contract and the medical staff bylaws.

The termination of the contract, in itself, is not reportable to the NPDB. The termination of the practitioner's clinical privileges because of the termination of the contract for reasons relating to professional competence or professional conduct is reportable if it is considered a professional review action by the hospital.

Hospitals are advised to consult with legal counsel to review the State's case law concerning due process.

Example 8: A physician surrenders medical staff privileges due to personal reasons, infirmity, or retirement.

The surrender is not reportable. The reasons for surrender are irrelevant unless the physician surrenders while under an investigation by a health care entity relating to possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation.

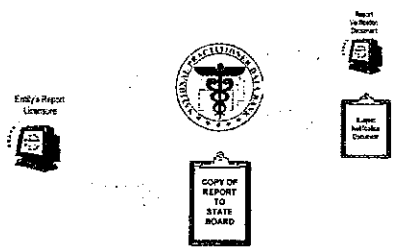
Example 9: A physician was under investigation four weeks prior to the expiration of his clinical privileges. The physician failed to renew his clinical privileges.

This event is considered a reportable surrender while under investigation. This action is reportable regardless of whether the physician knew he was under investigation at the time he failed to renew his clinical privileges. A practitioner's awareness that an investigation is being conducted is not a requirement for reportability.

Example 10: A physician holding courtesy privileges in a hospital applies for full staff privileges. The full staff privileges are granted. As a condition of staff privileges, the physician is required to be on-call in the Emergency Department for one weekend a month. Due to personal reasons, the physician is unable to fulfill his Emergency Department commitment. The hospital and the physician eventually agree to change his clinical privileges from full staff to courtesy.

The change in clinical privileges is not reportable. The change to the physician's privileges is not the result of a professional review action based on the physician's professional competence or conduct which affects or could adversely affect the health or welfare of a patient.

REPORTING ADVERSE LICENSURE ACTIONS



Reporting Adverse Licensure Actions

State medical and dental licensing boards must report adverse actions against physicians and dentists to the NPDB within 30 days from the date an adverse licensure action was taken.

State medical and dental boards must report to the NPDB certain disciplinary actions related to professional competence or professional conduct taken against the licenses of physicians or dentists. Such licensure actions include revocation, suspension, censure, reprimand, probation, and surrender. State medical and dental boards must also report revisions to adverse licensure actions, such as reinstatement of a license.

Effective Date of Action

An Adverse Action Report must be submitted within 30 days of the date of the formal approval of the licensure action by the State medical or dental board or its authorized official. Significant delays may occur between the formal approval of the action and the drafting of the order for publication; however, the trigger date for reporting the adverse action is based on the board's formal approval of the action.

Examples of Reportable Actions

The following adverse licensure actions, when related to the professional competence or professional conduct of a physician or dentist, must be reported to the NPDB:

- Denial of an application for license renewal.
- Withdrawal of an application for license renewal (should be reported as a voluntary surrender).
- Licensure disciplinary action taken by a State board against one of its licensees/applicants for licensure renewal based upon a licensure disciplinary action, related to the practitioner's professional competence or professional conduct, taken by another State board.

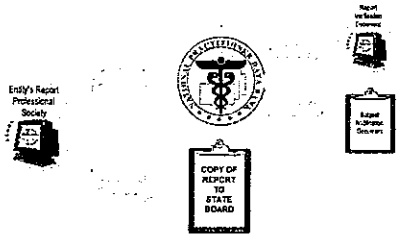
- Licensure disciplinary action taken by a State board based upon the practitioner's deliberate failure to report a licensure disciplinary action taken by another State board, when a report of such action is requested on a licensure renewal application.
- Fines and other monetary sanctions accompanied by other licensure action, such as revocation, suspension, censure, reprimand, probation, or surrender.

Examples of Non-Reportable Actions

The following adverse licensure actions should not be reported to the NPDB:

- Fines and other monetary sanctions unaccompanied by other licensure action, such as revocation, suspension, censure, reprimand, probation, or surrender.
- Denial of an initial application for license.
- A settlement agreement which imposes monitoring of a practitioner for a specific period of time, unless such monitoring constitutes a restriction of the practitioner's license or is considered to be a reprimand.
- A licensure disciplinary action which is imposed with a "stay" pending completion of specific programs or actions. However, if a "stay" of a disciplinary action is accompanied by probation, the probation is reportable.
- Voluntary relinquishment of a physician's license for personal reasons not related to his or her professional competence or professional conduct (for example, retirement).
- Licensure actions taken against non-physician, non-dentist, health care practitioners.

REPORTING ADVERSE PROFESSIONAL SOCIETY MEMBERSHIP ACTIONS



Reporting Adverse Professional Society Membership Actions

Professional societies must report adverse actions within 15 days from the date the adverse action was taken. A copy of each report sent to the NPDB should be printed and mailed to the appropriate State licensing board for its use.

The *Report Verification Document* that health care entities receive after a report is successfully processed by the NPDB should be used for submission to the appropriate State licensing board.

Reporting Requirements

Professional societies must report professional review actions based on reasons related to professional competence or professional conduct that adversely affect the membership of a physician or dentist. Professional societies may report such adverse membership actions when taken against health care practitioners other than physicians and dentists.

Reportable actions must be based on reasons relating to professional competence or professional conduct which affects or could adversely affect the health or welfare of a patient. Matters not related to the professional competence or professional conduct of a physician or dentist are not to be reported to the NPDB.

For example, adverse actions against a practitioner based primarily on his or her advertising practices, fee structure, salary arrangement, affiliation with other associations or health care professionals, or other competitive acts intended to solicit or retain business are excluded from NPDB reporting requirements.

An adverse action taken by a professional society against the membership of a physician or dentist must be reported to the NPDB when that action constitutes a professional review action taken in the course of professional review activity through a formal peer review process, provided that the action is based on the member's professional competence or

professional conduct. Adverse membership actions involving censures, reprimands, or admonishments should not be reported.

Reporting Medicare/Medicaid Exclusions

In 1997, reports of exclusions from the Medicare and Medicaid programs against health care practitioners* were added to the NPDB through a collective effort and a Memorandum of Understanding between HRSA, the HHS Office of Inspector General (OIG), and the Centers for Medicare & Medicaid Services (CMS). The NPDB now includes Medicare/Medicaid exclusions from May 1979 to the present.

NPDB Medicare/Medicaid exclusions identify practitioners who have been declared ineligible for Medicare and Medicaid payments. Hospitals, managed care organizations, and other providers are prohibited from billing the Medicare and Medicaid programs for any services that might be rendered by these providers. Information from the Medicare/Medicaid exclusions is released in accordance with the *Social Security Act*.

The HHS Office of Inspector General has the authority to exclude individuals and organizations from participating in the Medicare and/or certain State health care plans under sections 1128(a), 1128(b), 1892, or 1156 of the *Social Security Act*. The exclusion also applies to all other Executive Branch procurement and non-procurement programs and activities. Disclosure of the Office of Inspector General Exclusion List to HRSA is under authority of section 1106(a) of the *Social Security Act*, 42 CFR 401.105, and the routine use exception of the *Privacy Act* (5 U.S.C. 522a(b)(3)). CMS retains full responsibility for the content and accuracy of CMS exclusion reports; the NPDB only acts as a disclosure service. Notification of exclusion from CMS programs is made by CMS. Inquiries on the appropriateness or content of CMS exclusion reports must be referred to CMS for response.

**The NPDB contains Medicare/Medicaid exclusions against health care practitioners (i.e., physicians, dentists, chiropractors, psychologists, etc.). Exclusions against individuals other than licensed health care practitioners and entities, in addition to exclusions against health care practitioners, can be found in the Healthcare Integrity and Protection Data Bank (HIPDB).*

Sanctions for Failing to Report to the NPDB

Medical Malpractice Payers

The HHS Office of Inspector General has the authority to impose civil money penalties in accordance with Sections 421(c) and 427(b) of Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986*, as amended. Under the statute, any malpractice payer that fails to report medical malpractice payments in accordance with Section 421(c) is subject to a civil money penalty of up to $11,000 for each such payment involved.

The civil money penalties provided for under Sections 421(c) and 427(b) are to be imposed in the same manner as other civil money penalties imposed pursuant to Section 1128A of the *Social Security Act*, 42 U.S.C. 1320a-7a. Regulations governing civil money penalties under Section 1128A are set forth at 42 CFR Part 1003.

Hospitals and Other Health Care Entities

The Secretary of HHS will conduct an investigation if there is reason to believe that a health care entity has substantially failed to report required adverse actions. If the investigation reveals that the health care entity has not complied with NPDB regulations, the Secretary will provide the entity with written notice describing the noncompliance. This written notice provides the entity with the opportunity to correct the noncompliance, as well as notifies it of its right to request a hearing.

A request for a hearing must contain a statement of the material factual issues in dispute to demonstrate cause for a hearing and must be submitted to HHS within 30 days of receipt of notice of noncompliance. An example of a material factual issue in dispute is a health care entity refuting HHS's claim that the health care entity failed to meet reporting requirements.

A request for a hearing will be denied if it is untimely, lacks a statement of material factual issues in dispute, or if the statement is frivolous or inconsequential. Hearings are held in the Washington, DC, metropolitan area.

If HHS determines that a health care entity has substantially failed to report information in accordance with Title IV requirements, the name of the entity will be published in the *Federal Register*, and the entity will lose the immunity provisions of Title IV with respect to professional review activities for a period of 3 years commencing 30 days from the date of publication in the *Federal Register*.

State Boards

State medical and dental boards that fail to comply with NPDB reporting requirements can have the responsibility to report removed from them by the Secretary of HHS. In such instances, the Secretary will designate another qualified entity to report NPDB information. State medical or dental boards do not meet Title IV requirements when they fail to report licensure disciplinary actions required to be reported to the NPDB or fail to notify HHS when they are aware a health care entity is failing to report adverse actions it has taken against physicians and dentists.

When an HHS investigation substantiates such reporting failures, a written notice of noncompliance is sent to the State medical or dental board. This notice allows State medical and dental boards an opportunity to correct the situation. If the State medical or dental board fails to comply with the HHS notice, then HHS will designate another qualified entity for reporting to the NPDB.

Professional Societies

A professional society that has substantially failed to report adverse membership actions can lose, for 3 years, the immunity protections provided under Title IV for professional review actions it takes against physicians and dentists based on their professional competence and professional conduct.

The Secretary of HHS will conduct an investigation if there is reason to believe that a professional society has substantially failed to report adverse membership actions taken as result of professional review activity.

If the investigation reveals that the professional society has not complied with Title IV reporting requirements, HHS will inform the professional society of its noncompliance in writing. This written notice provides the professional society with the opportunity to correct the noncompliance, as well as notifies it of its right to request a hearing.

A request for a hearing must contain a statement of the material factual issues in dispute to demonstrate cause for a hearing and must be submitted to HHS within 30 days of receipt of notice of noncompliance. An example of a material factual issue in dispute is a professional society refuting HHS's claim that the health care entity failed to meet reporting requirements.

A request for a hearing is denied if it is untimely, lacks a statement of material factual issues in dispute, or if the statement is frivolous or inconsequential. Hearings are held in the Washington, DC, metropolitan area.

If HHS determines that a professional society has substantially failed to report information in accordance with Title IV requirements, the name of the entity will be published in the *Federal Register*, and the professional society will lose the immunity provisions of Title IV with respect to professional review activities for a period of 3 years commencing 30 days from the date of publication in the *Federal Register*.

Questions and Answers

1. **How long are reports held in the NPDB?**

   Information reported to the NPDB is maintained permanently unless it is corrected or voided from the system. A Correction or Void may only be submitted by the reporting entity or directed by the Secretary of HHS.

2. **Can my organization provide a copy of an NPDB report to the subject practitioner?**

   The NPDB appreciates entities that attempt to maintain an open exchange with subjects. However, if you provide a copy of the report to the subject, be sure to remove or obliterate your organization's DBID. The DBID should remain confidential to the organization to which it is assigned.

3. **Where can I find lists of Adverse Action Classification Codes, Basis for Actions Codes, and Malpractice Act(s) or Omission(s) codes?**

   Adverse action classification codes and medical malpractice act(s) or omission(s) codes are provided in pop-up lists in the respective IQRS web input screens. These codes also are found in the applicable Interface Control Document (ICD) that is available on the NPDB-HIPDB website.

Reporting Medical Malpractice Payments

4. **I am the new authorized submitter for a medical malpractice payer. I found some documentation of payments that were not reported to the NPDB. What should I do?**

   If the payments were made on or after September 1, 1990 (when the NPDB opened), submit reports on those payments to the NPDB. The regulations prescribe that any entity that fails to report a payment required to be reported is subject to a civil money penalty of up to $11,000 for each such payment. Submit the report through the IQRS and then send a letter to the NPDB that explains the circumstance of the report being submitted late. The NPDB will maintain this information for audit purposes.

5. **As a medical malpractice payer, do I have to report payments made for a deceased subject?**

   Yes. One of the principal objectives of the NPDB is to restrict the ability of incompetent practitioners to move from State to State without disclosure of their previous damaging or incompetent performance. Fraudulent practitioners may seek to assume the identity of a deceased practitioner.

6. **Must a written complaint be directed to the subject cited in the claim?**

   No. The definition of a medical malpractice complaint includes complaints "brought in any State or Federal court or other adjudicative body." If a patient files a written complaint with, for example, a State board, and a medical malpractice payment results, the payment must be reported to the NPDB.

7. **How does a medical malpractice payer report a payment if a total amount has not been determined and the payer is making an initial partial payment?**

   Complete the MMPR screens according to the instructions on the IQRS. Note the amount of the first payment and, in the narrative section, explain that the total amount has not been determined and the first payment is a partial payment. When the final amount is determined, submit a Correction to the Initial report, and note the final amount in the narrative section.

8. **Should payment exclusively for the benefit of a clinic or hospital be reported?**

   Medical malpractice payments made solely for the benefit of a clinic or hospital are not currently reportable to the NPDB.

9. **Our insurance company reimbursed a practitioner for a medical malpractice payment the practitioner made to a patient. Is this reportable?**

   Yes. An insurance company that reimburses a practitioner for such a payment (makes a payment in response to the medical malpractice claim or judgment) must report that payment to the NPDB, as long as the patient submitted the demand in writing.

10. **If a patient makes an oral demand for a refund for services, is the resulting payment reportable to the NPDB?**

    No. Only payments resulting from written demands are reportable to the NPDB. Even if the practitioner transmits the demand in writing to the medical malpractice payer, the payment is not reportable if the patient's only demand was oral. However, if a subsequent written claim or demand is received from the patient and results in a payment, that payment is reportable.

11. **If an individual practitioner is not named in a medical malpractice claim or complaint, but the facility or practitioner group is named, should the payment be reported?**

    No, with one exception. If the named defendant is a sole practitioner identified as a "professional corporation," a payment made for the professional corporation must be reported for the practitioner.

12. **A supervisory practitioner is named in an action based on the services of a subordinate practitioner. How do I report the supervisory practitioner?**

    The report on the supervisory practitioner should be submitted using the same malpractice claim description code used for the subordinate. The reporting entity may provide an explanation that the supervisory practitioner was named based on the subordinate practitioner's services in the narrative description.

13. **What are the reporting requirements for self-insured employers who provide professional liability coverage for their employed practitioners?**

    Employers who insure their employees must report medical malpractice payments they make for the benefit of their employees.

14. **If a stipulation of settlement or court order requires that its terms remain confidential, how does a medical malpractice insurer report the payment to the NPDB without violating the settlement agreement or court order?**

    Confidential terms of a settlement or judgment do not excuse an entity from the statutory requirement to report the payment to the NPDB. The reporting entity should explain in the narrative section of the MMPR that the settlement or court order stipulates that the terms of the settlement are confidential.

15. **If there is no medical malpractice payment and Loss Adjustment Expenses (LAEs) are paid in order to release or dismiss a healthcare practitioner from a medical malpractice suit, should the LAE be reported?**

    No. If LAEs are not included in the medical malpractice payment, then they should not be reported to the NPDB.

16. **When reporting a medical malpractice payment, should loss adjustment expenses be included in the payment amount?**

    LAEs should be reported only if they are part of the medical malpractice payment. Reporting requirements include the total amount of the payment and a description and amount of the judgment or settlement and any conditions, including terms of payment. LAEs should be itemized in the description section of the report. LAEs refer to expenses other than those in compensation of injuries, such as attorney's fees, billable hours, expert witness fees, deposition, and transcript costs. If LAEs are not included in the payment amount, they need not be reported.

17. **Are payments made for the benefit of residents, interns, and students reportable?**

    Payments made for the benefit of licensed residents and interns are reportable to the NPDB; payments made for the benefit of unlicensed medical or dental students are not reportable to the NPDB.

Reporting Adverse Licensure Actions

18. **How should a State board report an action with several levels or components, for instance, a 6-month license suspension followed by a 2-year probation?**

    The board should report the code of the principal sanction or action and describe its full order, including lesser actions, in the narrative of the AAR. An additional report is not necessary when the lesser sanction or action is implemented since it was included in the description in the Initial Report.

19. **How should a State medical or dental board report actions when they are changed by court order?**

    The board should report the initial adverse action as usual; the judicial decision is reported as a Revision to Action. For example, if a board revoked a physician's license and a judicial appeal resulted in the court modifying the discipline to probation for 1 year, then the board would be required to report both its initial revocation action and the court-ordered revision to a 1-year probation. When a court stays a board's order, this action may be reported as a Revision to Action, using the Adverse Action Classification Code for Reduction of Previous Action (1295). When a court overturns a Board's order, the Board should void the Initial Report.

20. **When reporting a reprimand by a State licensing board, what Length of Action should be entered on the report form?**

    The indefinite block should be marked on the appropriate report screen in the IQRS for reprimands reported to the NPDB.

Reporting Adverse Clinical Privileges Actions

21. **If we revoke a practitioner's clinical privileges because the practitioner lost his/her license, do we report the revocation?**

    Administrative actions that do not involve a professional review action are not reportable to the NPDB. Only actions resulting from professional review and lasting more than 30 days that are related to the professional competence or professional conduct of a practitioner should be reported to the NPDB. Thus, if the revocation of clinical privileges is automatic, the action should not be reported to the NPDB.

22. **Are adverse actions on clinical privileges reportable prior to hearings?**

    The action is not reportable until it is made final by the health care entity. An exception is made if an immediate (that is, summary) suspension or restriction subject to subsequent notice and hearing is enforced because of imminent danger to an individual's health and safety.

    A summary suspension of clinical privileges is not routinely considered a reportable event. However, if a summary suspension lasts longer than 30 days and is considered by the hospital or other health care entity to be a professional review action (which means that it is so defined in the organization's bylaws), then the entity must report the summary suspension. If the reported suspension is subsequently altered following a hearing or other procedures, the entity must submit a Revision to Action or Void.

23. **Are adverse actions on clinical privileges reportable prior to appeals?**

    Adverse actions on clinical privileges are not reportable until they are made final by the health care entity. If an internal administrative appeal preceding final action by the entity is provided for in the entity's bylaws, then the action is not reportable until the conclusion of this appeal. However, if a previously reported adverse action is subsequently modified or vacated after an appeal by the practitioner, the health care entity is responsible for submitting a Revision to Action or Void.

24. **A health care entity took an adverse action against a practitioner, but the action was enjoined before it was implemented. Should the action be reported to the NPDB?**

    Adverse actions are reportable only if they are in effect for at least 30 days. An adverse action enjoined prior to implementation should not be reported. However, if the adverse action has been in effect for 30 or more days and is then enjoined, the adverse action should be reported and the enjoinment should be reported as a Revision to Action.

25. **Are investigations reportable if they do not reach a conclusion?**

    Investigations are not reportable events; however, if a practitioner surrenders or fails to renew clinical privileges, or if privileges are restricted while the practitioner is either under investigation by a health care entity for possible incompetence or improper professional conduct, or to avoid an investigation, the surrender or restriction must be reported to the NPDB.

26. **A practitioner is under investigation relating to possible incompetence or improper professional conduct and resigns from the hospital. If the practitioner did not receive notification of the investigation, is this a reportable event?**

    Under the provisions of the *Health Care Quality Improvement Act*, the practitioner is not required to have direct knowledge of the investigation. Hospitals should be able to produce evidence of an on-going investigation in the event of questioning. See the Investigations section of this chapter for more information.

    To be considered reportable, a practitioner's resignation must be tendered "in order to prevent a professional review action." A resignation tendered with the understanding that the hospital will cease an investigation or professional review action is reportable.

27. **Must a hospital or other health care entity report adverse actions concerning the clinical privileges of medical and dental residents and interns?**

    Not if the action was taken within the scope of the training program. Since residents and interns are trainees in graduate health professions education programs, they are not granted clinical privileges *per se*, but are authorized by the sponsoring institution to perform clinical duties and responsibilities within the context of their graduate educational program.

    However, a resident or intern may practice outside the scope of the formal graduate education program, for example, moonlighting in the Intensive Care Unit or Emergency Department. Adverse clinical privileges actions related to practice occurring outside the scope of a formal graduate educational program are reportable.

28. **If an initial application for clinical privileges is denied or the privileges granted are more limited than those requested, must this be reported to the NPDB?**

    Yes, if the denial or limitation of privileges is the result of a professional review action and is related to the practitioner's professional competence or professional conduct.

29. **If an "impaired practitioner" enters a rehabilitation program, is it reportable?**

    The voluntary entrance of an impaired practitioner into a rehabilitation program is not reportable to the NPDB if no professional review action was taken and the practitioner did not relinquish clinical privileges. If a practitioner takes a leave of absence and clinical privileges have not been taken away, then no report to the NPDB is required.

    If an impaired practitioner is required by a professional review action to involuntarily enter a rehabilitation program, the professional review action is reportable to the NPDB if it is based on the practitioner's professional competence or professional conduct and adversely affects the practitioner's clinical privileges for more than 30 days.

    When completing the AAR input screen, the reporting entity can select an Adverse Action Classification Code of "Other" and explain in the narrative that the practitioner's privileges were restricted or suspended because of concerns regarding quality of care. Entities may wish to consult with their legal counsel regarding the wording of the narrative before it is submitted to the NPDB.

30. **An "impaired practitioner" member of a hospital medical staff has been repeatedly encouraged to enter a rehabilitation program. The practitioner continues to disregard the hospital's advice and offers of assistance. If an authorized hospital official, such as the CEO or Department Chair, directs the practitioner to give up clinical privileges and enter a rehabilitation program or face investigation relating to possible professional incompetence or improper professional conduct, is the surrender of clinical privileges reportable to the NPDB?**

    Yes. If the hospital CEO directs the practitioner to surrender his or her clinical privileges or face investigation by the hospital for possible professional incompetence or improper professional behavior, the surrender is reportable to the NPDB. The surrender of clinical privileges in exchange for not undergoing an investigation triggers a report to the NPDB, regardless of whether the practitioner is impaired [see §60.9 (a)(ii)(A) and (B) of the NPDB regulations].

31. **Laws related to drug and alcohol treatment programs have confidentiality provisions. Won't a report concerning a practitioner in a treatment program violate those provisions?**

    No. Only the adverse action affecting privileges must be reported; the fact that a practitioner entered a treatment or rehabilitation program should not be reported. If only the adverse action is reported as required, there is no violation of laws related to drug or alcohol treatment (42 USC. §290dd-3 and 290ee-3).

Reporting Adverse Membership Actions

32. **If a professional society denies membership to a practitioner, is it reportable to the NPDB?**

The action must be reported to the NPDB if the denial of membership was based on a professional review action conducted through a formal peer review process and was based on an assessment of the practitioner's professional competence or professional conduct which affected or could affect the health and welfare of a patient or patients. Denial of membership for reasons not related to professional competence or professional conduct which affects or could adversely affect the health and safety of a patient (advertising practices or fee structures, for example) should not be reported to the NPDB.

The Dispute Process

The NPDB is committed to maintaining accurate information and ensuring that health care practitioners are informed when adverse actions are reported about them. When the NPDB receives a report, the IQRS processes the information exactly as it is submitted by the reporting entity. Reporting entities are responsible for the accuracy of the information they report.

When the NPDB processes a report, a *Report Verification Document* is sent electronically to the reporting entity via the IQRS and can be accessed at the *Report Status* screen. A *Notification of a Report in the Data Bank(s)* is mailed to the subject. The subject should review the report for accuracy, including such information as current address and place of employment.

Subjects may not submit changes to reports. If any information in a report is inaccurate, the subject must request that the reporting entity file a correction to the report. The NPDB is prohibited by law from modifying information submitted in reports.

If the reporting entity declines to change the report, the subject may initiate a dispute of the report through the dispute process, add a statement to the report, or both. The dispute process is not an avenue to protest a payment or to appeal the underlying reasons of an adverse action affecting the subject's license, clinical privileges, or professional society membership. Neither the merits of a medical malpractice claim nor the appropriateness of, or basis for, an adverse action may be disputed.

Subjects who wish to add a statement to and/or dispute the factual accuracy of a report should follow the instructions on the *Notification of a Report in the Data Bank(s)*. Subjects who do not have the original *Notification of a Report in the Data Bank(s)* may obtain a *Subject Statement and Dispute Initiation* form from the NPDB-HIPDB web site at *www.npdb-hipdb.com*.

Subject Statements

The subject of a report may add a statement to the report at any time. When the NPDB processes a statement, notification of the statement is sent to all queriers who received the report, and is included with the report when it is released to future queriers. Subject Statements are limited to 2,000 characters, including spaces and punctuation. Drafting a statement in accordance with the character limits ensures that the statement contains the information a subject deems most important. All characters beyond 2,000 are truncated. Subject Statements cannot include any names, addresses, or phone numbers, including those of patients.

A Subject Statement is part of the specific report it is filed for. If the report is changed by the reporting entity, the statement attached to the report also is removed. If a statement is needed with the new report, a new statement that references the Data Bank Control Number (DCN) of the new report must be submitted.

Subject Disputes

The subject of a Medical Malpractice Payment Report (MMPR) or an Adverse Action Report (AAR) may dispute either the factual accuracy of the report or whether a report was submitted in accordance with the NPDB's reporting requirements, including the eligibility of the entity to report the information to the NPDB. A subject may not dispute a report in order to protest a decision made by an insurer to settle a claim or to appeal the underlying reasons for an adverse action.

If a subject believes that information in a report is factually inaccurate (e.g., an incorrect adverse action code or payment amount) or should not have been reported, (e.g., a clinical privileges action that lasts 30 days or less), the subject must attempt to resolve the disagreement directly with the reporting entity. **Changes to a report may be submitted only by the reporting entity.**

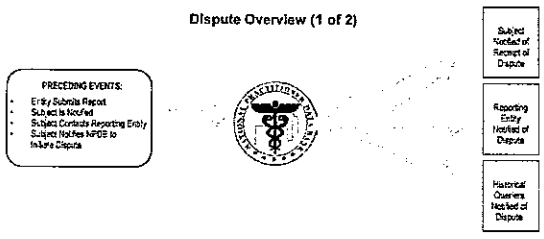
When the NPDB receives a properly completed Subject Statement and Dispute Initiation form from the subject initiating a dispute, notification of the dispute is sent to all queriers who received the report, and is included with the report when it is released to future queriers.

A dispute becomes part of the specific report it is contesting. If the report is changed by the reporting entity, the dispute notation attached to the report is also removed. If the subject believes that the new version of the report is factually inaccurate, the subject must initiate a new dispute.

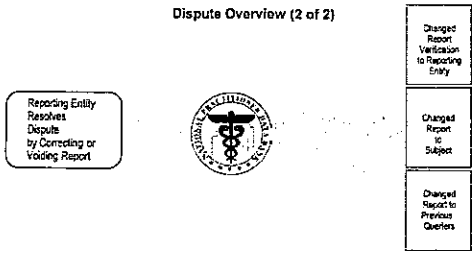
There are three possible outcomes for a dispute:

- The reporting entity corrects the report to the satisfaction of the subject.
- The reporting entity voids the report.
- The reporting entity declines to change the report.

Dispute Overview (1 of 2)



Dispute Overview (2 of 2)



Secretarial Review

If the reporting entity declines to change the disputed Adverse Action Report or Medical Malpractice Payment Report or takes no action, the subject may request that the Secretary of HHS review the disputed report. The Secretary reviews disputed reports only for accuracy of factual information and to ensure that the information was required to be reported.

The Secretary does not review the merits of a medical malpractice claim in the case of a payment or the appropriateness of, or basis for, a health care entity's professional review action or a State licensing board's action.

To request Secretarial Review of a disputed report, the subject must sign and return to the NPDB the *Instructions for Review of the Disputed Report by the Secretary of the U.S. Department of Health and Human Services* attached to the *Report Revised, Voided, or Status Changed* document related to the disputed report. The dispute and any accompanying documentation must be sent to the NPDB, not directly to the Secretary.

The subject also must:

- State clearly and briefly in writing which facts are in dispute and what the subject believes are the facts.
- Submit documentation substantiating that the reporting entity's information is inaccurate. Documentation must directly relate to the facts in dispute and substantially contribute to a determination of the factual accuracy of the report. Documentation may not exceed 10 pages, including attachments and exhibits.
- Submit proof that the subject attempted to resolve the disagreement with the reporting entity, but was unsuccessful. Proof may be a copy of the subject's correspondence to the reporting entity and the entity's response, if any.

- Wait 30 days from the date of initiating discussions with the reporting entity before requesting Secretarial Review to give the reporting entity time to respond to the dispute.

Pertinent Documentation

If the dispute relates to a Medical Malpractice Payment Report, pertinent documentation might include a copy of the following:

- Written claim.
- Settlement or release document.
- Court judgment.
- Written findings of arbitration or other alternative dispute resolution processes.

If necessary, the Secretary will ask the reporting entity to supply additional information confirming that the report was submitted in accordance with NPDB regulations. Entities must respond to the Secretary's request for more information within 15 days. After reviewing all documentation related to the dispute, the Secretary will determine whether the information in the disputed report is accurate and should have been reported to the NPDB.

If the dispute relates to an Adverse Action Report, pertinent documentation might include a copy of the following:

- The findings of fact and recommendations of the health care entity, professional society, or State licensing board.
- The final report of the hearing panel or other appellate body upon which the description of acts or omissions was based.

Secretarial Review Results

When the NPDB receives proper notice of a request for Secretarial Review, the materials are forwarded to the Secretary of HHS for review. There are three possible outcomes for Secretarial Review of a dispute:

- The Secretary concludes that the report is accurate.
- The Secretary concludes that the report is inaccurate.
- The Secretary concludes that the issues in dispute are outside the scope of Secretarial Review.

Report Accurate as Submitted

If the Secretary concludes that the information in the report is accurate, the Secretary sends an explanation of the decision to the subject. The subject may then submit, within 30 days, a statement that is added to the report. The statement is limited to 2,000 characters, including spaces and punctuation, and is entered into the NPDB computer system exactly as submitted. The new Subject Statement replaces any statement the subject submitted previously. If no new Subject Statement is received, any existing statement previously submitted by the subject is maintained as part of the report record.

The subject of the report, the reporting entity, and all queriers who received notice of the disputed report are each sent a *Report Revised, Voided, or Status Changed* document containing the Secretary's explanation and the subject's statement. Future queriers will receive the Secretary's and subject's statements with the report.

Report Inaccurate as Submitted

If the Secretary concludes that the report is inaccurate, the Secretary directs the NPDB to correct the information in the report. The subject of the report, the reporting entity, and all queriers who received notice of the disputed report are each sent a *Report Revised, Voided, or Status Changed* document informing them of the correction.

If the Secretary concludes that the report was submitted in error, the Secretary directs that the report be voided from the NPDB. The subject of the report, the reporting entity, and all queriers who received notice of the disputed report are each sent a *Report Revised, Voided, or Status Changed* document informing them that the report has been voided.

Dispute Outside the Scope of Secretarial Review

If the Secretary concludes that the issue in dispute is outside the scope of review, the Secretary directs the NPDB to add an entry to that effect to the report and to remove the dispute notation from the report. The subject may then submit, within 30 days, a statement that is added to the report. The statement is limited to 2,000 characters, including spaces and punctuation, and is entered into the NPDB computer system exactly as submitted. If no new Subject Statement is received, any existing statement previously submitted by the subject is maintained as part of the report record.

The subject of the report, the reporting entity, and all queriers who received notice of the disputed report are each sent a *Report Revised, Voided, or Status Changed* document informing them of the Secretary's decision.

Secretarial Review Overview

Reconsideration of the Secretary's Decisions on Disputes

Although HHS does not have a formal appeals process for reconsideration of the Secretary's decisions on disputes, HHS does review such requests. The subject must submit a written request for reconsideration to the office that issued the Secretary's determination. The subject should be specific about any new information that was unavailable at the time of Secretarial Review and which issues the practitioner believes were not appropriately considered during the review process. The Secretary will either affirm the prior determination or issue a revised finding. HHS, however, gives priority to initial requests for Secretarial Review.

Improper Requests for Secretarial Review

A request for Secretarial Review is considered improper when the report in question has not previously been disputed by the subject. Before requesting Secretarial Review, a subject must first attempt to resolve the disagreement with the reporting entity and then may dispute the report according to the instructions provided on the *Notification of a Report in the Data Bank(s)* document.

If a subject submits an improper request for Secretarial Review, the NPDB will notify the subject that the report must first be disputed and resolution attempted with the reporting entity.

Examples of Disputes

Due Process - Alleged Denial

Example: A practitioner alleged that an entity, during professional review, denied the practitioner due process because the reviewers ignored the testimony of medical experts or other witnesses called to prove various points the practitioner felt important to the defense.

Outcome: The Secretary determined that the dispute request was outside the scope of review and made an entry to that effect in the report. The dispute notation was removed from the report.

Due Process - Legal Action Pending

Example: A practitioner disputed a report on the revocation of his or her clinical privileges by a hospital on the basis that due process was denied during professional review. The practitioner further stated that since he or she had initiated a legal action against the hospital regarding the due process, the report should be removed from the NPDB until legal action is resolved.

Outcome: The Secretary determined that the dispute request was outside the scope of review. The Secretary additionally stated that if a court action resulted in a reportable change to the action previously reported, a second report must be submitted by the reporting entity. This new report could make corrections, be a revision to the action, or be a void of the prior report.

Licensure Completion - Trigger Date

Example: A pharmacy student committed an act of alleged malpractice while in training in the pharmacy of a retail store. The student had no license at the time of the alleged act. However, at the time the payment was made on the student's behalf, the student had completed training and received a license. The practitioner disputed the report on the basis that a practitioner must be licensed at the time of the alleged incident in order for a report to be made to the NPDB.

Outcome: The Secretary directed that the report be voided from the NPDB since it has been determined that the appropriate trigger date for determining if the practitioner is licensed is the date on which the reported incident occurred, not the date on which the payment was made.

Narrative Description - Inaccurate

Example: A practitioner disputed a report of a licensure disciplinary action taken by a State board of medical examiners stating that the narrative regarding the act or omission was not accurate. The practitioner requested that the description be changed to reflect the findings of the board.

Outcome: The Secretary reviewed the narrative against the findings reported by the State board and determined that the report would be accurate if the actual language from the board's findings were used. The Secretary directed the NPDB to change the narrative. The dispute notation was removed from the report.

Narrative Description - Legal Sufficiency

The purpose of the narrative description section of the report is to describe the acts, omissions, or reasons for the action reported. Section 423(a)(3)(B) of the *Health Care Quality Assurance Act* [42 U.S.C., Section 11133(a)(3)(B)] requires such "description of the acts or omissions or other reasons for the action." The legislative history states that the narrative "... does not necessarily require an extensive description of the acts or omissions or other reasons for the action or, if known, for the surrender. It does, however, require sufficient specificity to enable a knowledgeable observer to determine clearly the circumstances of the action or surrender."

A significant number of reports do not meet these legal requirements. The following are examples of legally inadequate descriptions found in the narrative description section of disputed reports:

Example 1: "Dr. X was found to exhibit improper and unprofessional conduct."

Example 2: "The ABC Hospital Board took final action on January 2, 1994, instituting a mandatory concurring consultation and monitoring requirement for a 6-month period, following an appeal by Dr. Y."

Example 3: "See attached letter."

Outcomes: The Secretary required the reporting entities to correct the reports to include more descriptive/explicative narratives. The contents of attachments are not entered into reports.

Narrative Description - Misleading

Example: A practitioner disputed a hospital's report that he resigned while under investigation. The narrative stated that there were no questions of professional competence or conduct, but that the issues that led to the investigation and the resignation were problems in the practitioner's bedside manner.

Outcome: The Secretary found that the report should be voided because the reason for the investigation as shown in the narrative was unrelated to professional competence or conduct. The hospital changed the narrative of the report to indicate that the investigation was undertaken as a matter of professional competence due to a misdiagnosis of a patient in the emergency room. The practitioner disputed this revised report. The Secretary reviewed the corrected report and the supporting material submitted by the hospital and found that the corrected report showed a reportable event.

It is unclear why the hospital submitted the initial report with language in the narrative that made the resignation appear unreportable. This case serves to emphasize the importance of providing accurate and complete information when composing the narrative section of a report.

Privileges - Resignation and Surrender While Under Investigation

Example: A practitioner disputed a report that he had resigned privileges during an investigation concerning professional competence. The practitioner disputed the report on the basis that he was unaware of any investigation and did not believe one was ongoing at the time. The practitioner also stated that he did not resign in order to avoid a review, but because his contract was expiring and he had found a new job.

Secretary's Response: The Secretary requested that the entity submit contemporaneous documentation showing that the entity had undertaken an investigation of the physician. Such documentation might have included findings of reviewers or directives of the executive committee or other professional review bodies in the hospital, or minutes from a professional review entity. The entity was unable or unwilling to provide any documentation that an investigation was occurring at the time the practitioner left. Since no contemporaneous documentation of an ongoing investigation was provided, the Secretary determined that the report should be voided.

The Secretary also stated that the practitioner need not be aware of an ongoing investigation at the time of the resignation in order for the entity to report the resignation to the NPDB, since many investigations start without any formal allegation being made against the practitioner. The reason the practitioner gives for leaving an entity while under investigation is irrelevant to reportability of the resignation.

Privileges - Suspension and Hospital Motivation

Example: A practitioner disputed the report of a suspension of clinical privileges. The practitioner claimed that the motivation for the action was a personality conflict with the chairman of his department, a matter unrelated to professional competence.

Outcome: The Secretary determined that the dispute request was outside the scope of review since the motivation of the hospital or individuals involved in the case is not reviewed by the Secretary and made an entry to that effect in the report. The dispute notation was removed from the report.

Professional Review - Alternative Employment Termination Procedure

Example: A practitioner disputed a report of the revocation of clinical privileges. The hospital has a system of professional review established under its bylaws and delivers health care services. The hospital also has an "employment termination procedure." The employment termination procedure was used by the hospital to end a practitioner's employment without use of the professional review process. The practitioner's privileges were revoked by the employment termination process, but no action was taken through the professional review process.

The practitioner was given no option in how the termination would occur.

Outcome: The Secretary directed that the report be voided from the NPDB since the professional review process had not been followed in terminating the practitioner's privileges. The termination was not a professional review action.

Some hospitals have stated that if they follow professional review procedures to remove the practitioner's privileges, they must then follow employment termination procedures in order to fire the practitioner. Hospitals have stated that by following the employment termination procedures, practitioners' privileges will automatically terminate. One hospital required all physicians on staff to waive their rights to the professional review process as a condition of employment. Health care entities are reminded that in order to be reportable to the NPDB, adverse actions must be the result of professional review.

Residency Status

Example: A licensed medical resident disputed a Medical Malpractice Payment Report on the basis that she was in training at the time of the incident.

Outcome: The Secretary determined that the dispute request was outside the scope of review and made an entry to that effect in the report. The payment is reportable if the practitioner (regardless of resident status) is named in both the claim and settlement or judgement and a payment is made on his or her behalf. The dispute notation was removed from the report.

Responsibility for Treatment

Example: A practitioner disputed a Medical Malpractice Payment Report because she saw the patient only once and was not responsible.

Outcome: The Secretary determined that the dispute request was outside the scope of review and made an entry to that effect in the report. The number of times a patient is seen by a practitioner or the level of responsibility is irrelevant to

reporting a medical malpractice payment. The dispute notation was removed from the report.

Settlement - Subject Disagrees

Example: A practitioner disputed a Medical Malpractice Payment Report on the basis that he did not concur with the settlement.

Outcome: The Secretary determined that the dispute request was outside the scope of review since the practitioner's agreement to a settlement is irrelevant to the reportability of the payment. The Secretary made an entry to that effect in the report, and the dispute notation was removed from the report.

Settlement - Subject Dismissed from Lawsuit

Example: A practitioner disputed a Medical Malpractice Payment Report on the basis that she was dismissed from the lawsuit by summary judgment before the settlement. The order granting summary judgment provided that the practitioner be dismissed from the lawsuit as having no liability, and that the plaintiff make no recovery against the practitioner.

Outcome: The Secretary directed the NPDB to void the report since no claim existed against the practitioner and no payment was made on his or her behalf. Although the insurance company may have named the practitioner in the release or settlement, any payment made would not be on behalf of this practitioner due to the summary judgment order.

Suspension - Indefinite Length

Example: A practitioner disputed a report of a summary suspension of clinical privileges on the basis that the suspension was less than 30 days. The hospital reported the suspension of the practitioner's clinical privileges on the 10th day of an indefinite suspension. Attendant to the suspension was a requirement that the practitioner complete a specific course of action (a psychiatric evaluation). When that action was completed, the hospital's professional review body reinstated the practitioner's clinical privileges. The practitioner completed the required action on the 20th day of the suspension and clinical privileges were immediately restored. The suspension of the practitioner's clinical privileges did not exceed 30 days, but the hospital did not request that the report be voided from the NPDB.

Outcome: The Secretary directed the NPDB to void the report since the duration of the suspension of the practitioner's clinical privileges did not exceed 30 days.

When a summary suspension is indefinite in length, it should not be reported until it has been in effect for more than 30 days.

Suspension - Summary

Example: A report was made to the NPDB regarding a summary suspension based on a practitioner's professional competence, which did not last more than 30 days. The hospital took no reportable action following the summary suspension. The practitioner disputed the report since the length of the suspension was less than 30 days. The practitioner resigned a year later while still under investigation by the

hospital for the same type of professional competency issue. The hospital submitted a report of the practitioner's resignation while under investigation. The practitioner disputed this report on the grounds that the same issue had previously been reported to the NPDB.

Outcome: The Secretary directed the NPDB to void the first report since the suspension did not exceed 30 days. The Secretary determined the second report to be correct as submitted since the resignation of the practitioner was submitted while under investigation for issues related to professional competence.

The practitioner was correct that the reason for the report was the same; however, reportability hinges not upon the nature of the problem or incident, but on the circumstances under which the report was made (the suspension versus the resignation while under investigation).

Questions and Answers

1. **I am the executor of my wife's estate. I received notification of a report about her in the NPDB. Can I dispute the report?**

   Yes. To dispute a report on your wife's behalf, you must provide documentation that you have been appointed the executor or legal representative of her estate. Acceptable documentation can be a photocopy of her will or other legal documentation showing you as the executor/legal representative.

2. **When a subject attempts to resolve a disagreement with a reporting entity, must the dispute be resolved within a certain time frame?**

   No. A subject must inform the reporting entity, in writing, of the disagreement with the report and the basis for that disagreement, but there is no requirement that the dispute must be resolved within a certain amount of time.

3. **If a subject wishes to dispute a report, does the subject have to submit a statement at the time of dispute?**

   No. The subject may provide a statement with the initiation of dispute, but is not required to do so. A Subject Statement may be submitted at any time.

4. **Must a subject initiate a dispute in order to add a statement to a report?**

   No. The subject of a report may add a statement to a report independently of the dispute process.

5. **If the Secretary rules a dispute to be beyond the scope of review and places a notation to this effect in the NPDB, can the subject also add a statement?**

   Yes. Subjects are notified of this option by the Secretary. A Subject Statement added to the report after dispute resolution replaces any prior Subject Statement.

Query Fees

Entity Query Fees

Fees are charged for all queries submitted to the NPDB. The query fee is based on the cost of processing requests and providing information to eligible entities. The fee is levied on a per-name basis. When multiple-name (i.e., batch) queries are submitted, the number of names in the query is multiplied by the per-name fee. If an eligible entity has registered for both the NPDB and the HIPDB and has selected the option to query both Data Banks (in Section D of the *Entity Registration* form), each query is processed against both Data Banks and assessed the current fee for each Data Bank.

The act of submitting a query to the NPDB is considered an agreement to pay the associated fee. A fee is assessed when a query is:

- Processed by the NPDB, regardless of whether there is information on file regarding a subject.
- Rejected by the NPDB because it is improperly completed or lacks required information.

Even when an entity designates an authorized agent to query and/or report on behalf of the entity, the entity is ultimately responsible for payment. Contractual arrangements with authorized agents should include procedures for payment of query fees.

Query fees are subject to change. The Secretary of HHS announces any changes in the *Federal Register*. Query fees are based on the date of receipt at the NPDB.

Self-Query Fees

A practitioner may submit a self-query at any time. Self-query requests for individuals are automatically sent to both the NPDB and the HIPDB, and self-queriers are assessed a fee for each Data Bank. All self-queries must be submitted through the NPDB-HIPDB web site at *www.npdb-hipdb.com*. After completing the on-line application, a self-querier should print the formatted copy, sign it (in ink) in the presence of a notary public, and mail the notarized form to the NPDB-HIPDB at the address noted on the form.

Methods of Payment

The NPDB accepts payment by credit card (VISA, MasterCard, or Discover) or pre-authorized Electronic Funds Transfer (EFT). All self-query fees must be paid by credit card. Personal checks, money orders, or cash are not accepted.

Entities choosing to pay by credit card do not have to make advance arrangements with the NPDB. The user should enter the credit card number and expiration date on the appropriate IQRS screen when creating a query. (Note: Credit card information must be entered each time a query file is created; the IQRS does not currently store this information.)

Entities choosing to pay by EFT must submit an *Electronic Funds Transfer Authorization* form before EFT payments can be processed. The form is available at *www.npdb-hipdb.com*. Entities must provide their Data Bank Identification Number (DBID), bank routing code, account number, the type of account (checking or savings), attach a voided blank check to the form, and sign the form in ink to establish an EFT. Once the

completed form has been submitted, the NPDB-HIPDB will establish electronic communications with the entity's bank. This process takes approximately two weeks. The entity will receive verification by mail that the EFT account has been set up successfully. Entities should verify the information for accuracy and, if there are any errors, mark their corrections on the document, sign and date it, and return it to the NPDB-HIPDB. If the information is correct, the entity should retain it for future reference.

Once an entity receives verification, it may begin to pay for query fees using EFT. Query charges will be deducted automatically from the entity's designated EFT account. Unlike the process of paying by credit card, the user does not need to enter EFT account information when creating a query.

Entities are responsible for ensuring that adequate funds are present in their account at the time queries are submitted for processing to avoid interruption and potential termination of services with the Data Banks. If an entity's EFT information changes, the entity is responsible for notifying the Data Banks by submitting a new *Electronic Funds Transfer Authorization* form.

Eligible entities may elect to have outside organizations query and/or report to the Data Banks on their behalf. Such an organization is referred to as the authorized agent (see Chapter D, Queries, for more information about authorized agents). The entity may choose to have the query charge assessed to either the agent's or the entity's credit card or EFT account. Agents that plan to charge query fees to their EFT account must complete an *Electronic Funds Transfer Authorization* form before EFT payments can be processed. If the entity intends for the fees for queries submitted by the agent to be assessed to either the agent's or the entity's EFT account, the entity must indicate this preference on the *Authorized Agent Designation* form, available at *www.npdb-hipdb.com*.

Entities and agents may view query charges on the *Billing History* screen within the IQRS. This screen provides the most current information available for entities and agents to better reconcile query charge amounts as they appear on their EFT or credit card statements. For each query submission, the *Billing History* screen provides the following information: the Data Bank Control Number (DCN) assigned to the query submission, the Data Bank(s) queried, the number of queries processed and charged compared to the total number of queries in that submission, the date the credit card or EFT account was charged, the amount charged, the type of payment used, the last four digits of the account number, and the processing status of the bill.

Entities also receive a Charge Receipt with their query responses. This document, along with the information on the *Billing History* screen, may be used by entities for accounting purposes. The Charge Receipt provides a list of the queried subjects, the search results, and the associated query fees.

An EFT Charge Receipt also contains the following information:

- Data Bank Identification Number (DBID)
- Entity Name
- Entity Address
- Payment Method

- Account Number
- Transaction Date (Date Queried)
- Transaction Number
- Current Date
- Number of Subjects in Query
- Number of Subjects Processed With Charge
- Number of Subjects Previously Processed
- Number of Subjects Not Processed
- Fee Per Subject
- Total Charge

A Credit Card Charge Receipt contains the following information:

- Data Bank Identification Number (DBID)
- Entity Name
- Entity Address
- Payment Method
- Account Number
- Expiration Date
- Transaction Date (Date Queried)
- Transaction Number
- Date Charged
- Number of Subjects in Query
- Number of Subjects Processed With Charge
- Number of Subjects Previously Processed
- Number of Subjects Not Processed
- Fee Per Subject
- Total Charge

The Number of Subjects Not Processed field refers to any query that has a "Pending" status. A status of "Pending" is assigned to any query that requires additional research before it can be completed. Credit cards are billed only when the status for a subject is indicated as "Complete." The Charge Receipt includes the processing and fee information for all subject names processed within a query, regardless of the date that each per-name fee was charged.

Account Discrepancies

If your EFT account information (e.g., routing number, bank account information) changes, you must submit a new *Electronic Funds Transfer Authorization* form that contains the new information. You must ensure that your account information is kept current to avoid interruption of NPDB services.

The NPDB-HIPDB collects outstanding query fee balances. The NPDB-HIPDB will request the entity to complete an *Account Balance Transfer Request* form to authorize settlement of an outstanding balance. The form is available at *www.npdb-hipdb.com*. There is no time limitation associated with the collection of an unpaid query charge.

Reconciliation of credit card statements must be done through the bank that issued the credit card. If you believe that your credit card or your EFT account should be credited or debited, contact the NPDB-HIPDB Customer Service Center for assistance. The NPDB will research the discrepancy and provide you with a resolution or a request for more information.

Credits and Debits

The NPDB issues credits when:

- A fee is incorrectly assessed.
- The NPDB causes a data processing error.

The NPDB issues debits when:

- A credit is mistakenly applied to an account.
- An original charge is not paid.

Requests for credits should be made within a 60-day period. If you suspect that your bill is incorrect, or if you need more information about a transaction on your bill, please write us as soon as possible. We must hear from you no later than 60 days after you submitted the query on which the error or problem appeared. You may call us at 1-800-767-6732 to report the error, but doing so will not preserve your rights. Your letter must provide the following information:

- Your name and credit card or EFT account number
- The dollar amount of the suspected error
- A description of the error and explanation of why you believe there is an error
- Your entity's and/or agent's Data Bank Identification Number (DBID)
- Your telephone number
- Your signature
- A copy of your bill

The NPDB has the right to collect all outstanding balances without prior approval from the customer. This collection authority does not expire.

If your organization is due a credit, the credit must be requested in writing within the time period set forth by the NPDB-HIPDB. After this period, no refunds will be warranted. In the event of a merger or acquisition of another entity, the new organization is responsible for payment of any outstanding debt of the prior organization.

Bankruptcy

Entities are responsible for notifying the NPDB of bankruptcy in writing and must include the following information:

- DBID
- Entity Name
- Entity Address
- Type of Bankruptcy - Chapter 7, Chapter 9, Chapter 11, or State Liquidation

If your organization is undergoing bankruptcy, the outstanding balance is still collectable until final resolution of the bankruptcy. Failure to make payments to the Data Bank(s) can result in your organization being terminated from access to the Data Bank(s).

Questions and Answers

1. **How does an entity request a credit from the NPDB?**

   The entity may request a credit by submitting the necessary details and supporting documentation (e.g., the query Data Bank Control Number, query batch number if part of a multiple-name submission, and billing statement) to the NPDB in writing.

2. **Does the NPDB reconcile credit card mistakes?**

   The NPDB cannot answer questions regarding credit card account statements sent to you by the bank that issued your credit card, nor can the NPDB address or investigate unauthorized charges. Please contact the bank that issued the credit card for assistance.

3. **My hospital is in Chapter 7 bankruptcy. Can it continue to query the NPDB?**

   If your hospital has ongoing business and is functioning as a hospital while concluding its liquidation, even under a debtor-in-possession, it must continue to query the NPDB. If it is in liquidation solely for the purpose of sale of assets and there is no ongoing business as a hospital, there is no reason for your organization to query and your DBID will be deactivated. Your organization is responsible for notifying the NPDB of its status. If the hospital comes under new ownership, the new owner must register with the NPDB and is responsible for fulfilling its reporting and querying obligations.

4. **My hospital is in Chapter 9 bankruptcy. Can it continue to query the NPDB?**

   Yes. Your hospital will be charged for all queries submitted after the NPDB receives notice of the filing of the Petition for Bankruptcy. Organizations that have an obligation to query the NPDB (i.e., hospitals) must still meet their querying obligations.

5. **My hospital is in Chapter 11 bankruptcy. Can it continue to query the NPDB?**

   Yes. Your organization will be charged for all queries submitted after the NPDB receives notice of the filing of the Petition for Bankruptcy. Organizations that have an obligation to query the NPDB (i.e., hospitals) must still meet their querying obligations.

6. **My hospital has been liquidated by the State. Can it continue to query the NPDB?**

   If your hospital has ongoing business and is functioning as a hospital while concluding its liquidation, it must continue to query the NPDB. Once the liquidation process has concluded or your organization has no ongoing business as a hospital, there is no reason for your organization to query and your DBID will be deactivated. Your organization is responsible for notifying the NPDB of its status. If the hospital comes under new ownership, the new owner must register with the NPDB and is responsible for fulfilling its reporting and querying obligations.

NPDB-HIPDB Web Site Assistance

The National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank (NPDB-HIPDB) web site, located at *www.npdb-hipdb.com*, allows you to interact with the NPDB-HIPDB more easily and quickly. By using your personal computer and the Internet, you can instantly access:

- The Integrated Querying and Reporting Service (IQRS) where Data Bank querying and reporting occurs. The IQRS contains several security features to prevent unauthorized access and ensure the confidentiality of information.
- The *Self-Query Options* screen, where you may complete an individual or organization self-query application and then print a formatted copy for notarization before mailing it to the NPDB-HIPDB. You may also view the status of a self-query that was previously transmitted to the Data Bank(s).
- The NPDB and HIPDB *Guidebooks*.
- Fact Sheets and Forms, including the *Entity Registration* form, *Authorized Agent Registration* form, *Authorized Agent Designation* form, and *Electronic Funds Transfer Authorization* form.
- A list of authorized agents.
- The NPDB and HIPDB governing statutes and regulations.
- The NPDB and HIPDB interactive training programs.
- General information on the Data Banks.
- Instructions and requirements for querying and reporting, including subject self-queries.
- Answers to frequently asked questions (FAQ).
- Criteria for entity eligibility.
- Information on the dispute process.
- An archive of NPDB-HIPDB newsletters and other publications.

The NPDB-HIPDB web site includes information on how to contact the Data Banks. Please visit the web site to instantly access information and find answers to your questions.

NPDB-HIPDB Customer Service Center

For additional assistance, contact the NPDB-HIPDB Customer Service Center by e-mail at *npdb-hipdb@sra.com*, or by phone at 1-800-767-6732 (TDD 703-802-9395).

Information specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB-HIPDB Customer Service Center is closed on all Federal holidays.

Data Bank Addresses

Requests for general information about the Data Banks and requests for Dispute and Secretarial Review materials should be addressed to:

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

Overnight mail delivery address:

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
4094 Majestic Lane
PMB-332
Fairfax, VA 22033

Phone numbers:

NPDB-HIPDB Customer Service Center:
1-800-767-6732
Outside the U.S.: 1-703-802-9380
Fax: 1-703-502-1222
TDD 1-703-802-9395

Requests for aggregate research data* must be addressed to:

Division of Quality Assurance
Research and Disputes Branch
7519 Standish Place
Suite 300
Rockville, MD 20857

* There may be a charge for some data requests.

Interpretation of NPDB Statutes and Regulations

The Division of Quality Assurance, Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services, is the Government agency responsible for administering the NPDB and for interpreting NPDB requirements. Matters that deal specifically with the legal interpretation of statutory and regulatory authority, should be directed to:

Associate Director for Policy
Division of Quality Assurance
Policy Branch
7519 Standish Place
Suite 300
Rockville, MD 20857

The Privacy Act and the NPDB

The *Privacy Act* (5 USC §552a) protects the contents of Federal systems of records on individuals, like those in the NPDB from disclosure without the individual's consent, unless the disclosure is for a routine use of the system of records as published annually in the *Federal Register*. The published routine use of NPDB information, which are based on the laws and the regulations under which the NPDB operates, does not include disclosure to the general public.

Write to the address in the Interpretation of NPDB Statute and Regulations section, above, for more information.

The Freedom of Information Act and the NPDB

The NPDB, as an agency of the United States, is required to release records to the public with certain exceptions under the provisions of the *Freedom of Information Act* (FOIA), 5 USC §552. The law creating the NPDB, the *Health Care Quality Improvement Act of 1986*, as amended, Title IV of P.L. 99-660, provides for limited access to NPDB information by certain authorized individuals and entities and, under the provisions of the *Privacy Act*, 5 USC §552a, protects practitioner information from unauthorized access. The limited access provision of the *Health Care Quality Improvement Act of 1986*, as amended, may affect the disclosure requirements of FOIA. The Health Resources and Services Administration of the Department of Health and Human Services processes FOIA requests. For information about the FOIA as it relates to the NPDB, please direct your inquiry to:

HRSA Freedom of Information Officer
Health Resources and Services Administration
7519 Standish Place
Suite 300
Rockville, MD 20857
(301) 443-2865

Federal Employer Identification Number

The Federal Employer Identification Number (FEIN) is used by paying entities for billing purposes as a vendor identification number. The vendor name, address, and FEIN for the NPDB are as follows:

HRSA, Department of Health and Human Services
7519 Standish Place
Suite 300
Rockville, MD 20857

FEIN: 52-082-1668

State Medical and Dental Boards

Addresses and phone numbers for State Medical and Dental Boards are listed in alphabetical order by State. Street addresses that are different than mailing addresses are listed in italics. This information is current as of the publication date of this *Guidebook*.

ALABAMA

Alabama State Board of Medical Examiners
P.O. Box 946
Montgomery, AL 36101-0946
848 Washington Avenue
Phone: (334) 242-4116
Fax: (334) 242-4155
Web Site: http://www.albme.org/
E-mail: bmedixon@mindspring.com

Alabama Medical Licensure Commission
P.O. Box 887
Montgomery, AL 36101-0887
Phone: (334) 242-4153
Fax: (334) 242-4155
Web Site: http://www.albme.org/
E-mail: bmedixon@mindspring.com

Board of Dental Examiners of Alabama
2227 Pansy Street, Suite B
Huntsville, AL 35801
Phone: (205) 533-4638
Fax: (205) 533-4690
E-mail: bdeal@compuserve.com

ALASKA

Alaska State Medical Board
3601 C Street, Suite 722
Anchorage, AK 99503-5986
Phone: (907) 269-8160
Fax: (907) 269-8156
Web Site: http://www.dced.state.ak.us/oce/pmed.htm

Alaska Board of Dental Examiners
P.O. Box 110806
Juneau, AK 99811-0806
Phone: (907) 465-2542
Fax: (907) 465-2974
Web Site: http://www.dced.state.ak.us/oce/pden.htm

ARIZONA

Arizona Board of Medical Examiners
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258-5539
Phone: (480) 551-2700
Toll Free: 877-255-2212
Fax: (480) 551-2704
Web Site:
http://www.docboard.org/bomex/index.htm
E-mail: questions@bomex.org

Arizona Board of Osteopathic Examiners in Medicine and Surgery
9535 E. Doubletree Ranch Road
Scottsdale, AZ 85258
Phone: (480) 657-7703
Fax: (480) 657-7715
Web Site: http://www.azosteoboard.org/
E-mail: information@azosteoboard.com

Arizona Board of Dental Examiners
5060 North 19th Avenue, Suite 406
Phoenix, AZ 85015
Phone: (602) 242-1492
Fax: (602) 242-1445

ARKANSAS

Arkansas State Medical Board
2100 Riverfront Drive, Suite 200
Little Rock, AR 72202
Phone: (501) 296-1802
Fax: (501) 296-1805
Web Site: http://www.armedicalboard.org/
E-mail: office@armedicalboard.org

Arkansas State Board of Dental Examiners
101 East Capitol, Suite 111
Little Rock, AR 72201
Phone: (501) 682-2085
Fax: (501) 682-3543
Web Site: http://www.asbde.org/
E-mail: asbde@mail.state.ar.us

CALIFORNIA

Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
Phone: (916) 263-2466
Toll Free: 800-633-2322
Fax: (916) 263-2387
Web Site: http://www.medbd.ca.gov/

Osteopathic Medical Board of California
2720 Gateway Oaks Drive, Suite 350
Sacramento, CA 95833
Phone: (916) 263-3100
Fax: (916) 263-3117
Web Site: http://www.docboard.org/cx/
E-mail: ljhombc@inreach.com

Dental Board of California
1432 Howe Avenue, Suite 85-B
Sacramento, CA 95825
Phone: (916) 263-2300
Fax: (916) 263-2140
Web Site: http://www.dca.ca.gov/r_r/dentalbd.htm

COLORADO

Colorado State Board of Medical Examiners
1560 Broadway, Suite 1300
Denver, CO 80202-5140
Phone: (303) 894-7690
Fax: (303) 894-7692
Web Site: http://www.dora.state.co.us/medical
E-mail: medical@dora.state.co.us

Colorado State Board of Dental Examiners
1560 Broadway, Suite 1310
Denver, CO 80202
Phone: (303) 894-7758
Fax: (303) 894-7764
Web Site: http://www.dora.state.co.us/dental
E-mail: dental@dora.state.co.us

CONNECTICUT

Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308
Phone: (860) 509-8000
Web Site: http://www.state.ct.us/dph/

DELAWARE

Delaware Board of Medical Practice
P.O. Box 1401
Dover, DE 19903
Cannon Building, Suite 203, 861 Silver Lake Blvd., Dover, DE 19904
Phone: (302) 739-4522 Ext. 211
Fax: (302) 739-2711

Delaware State Board of Dental Examiners
P.O. Box 1401
Dover, DE 19903
Cannon Building, Suite 203, 861 Silver Lake Blvd., Dover, DE 19904
Phone: (302) 739-4522 Ext. 220
Fax: (302) 739-2711

DISTRICT OF COLUMBIA

District of Columbia Board of Medicine
825 N. Capitol Street, N.E., 2nd Floor
Washington, DC 20002
Phone: (202) 442-9200
Fax: (202) 442-9431
Web Site: http://www.dchealth.com

District of Columbia Board of Dentistry
Department of Consumer and Regulatory Affairs
614 H Street, N.W., Room 904
Washington, DC 20001
Phone: (202) 727-7478

FLORIDA

Florida Board of Medicine
4052 Bald Cypress Way, Bin CO3
Tallahassee, FL 32399-3253
Phone: (850) 245-4131
Fax: (850) 922-3040
Web Site: http://www.doh.state.fl.us/mqa/medical/mehome.htm

Florida Board of Osteopathic Medicine
4052 Bald Cypress Way, Bin CO6
Tallahassee, FL 32399-3256
Phone: (850) 488-0595
Fax: (850) 921-6184
Web Site: http://www.doh.state.fl.us/mqa/osteopath/oshome.htm

Florida Board of Dentistry
4052 Bald Cypress Way, Bin CO6
Tallahassee, FL 32399-3256
Phone: (850) 488-0595
Fax: (850) 921-6184
Web Site: http://www.doh.state.fl.us/mqa/dentistry/dnhome.htm

GEORGIA

Georgia Composite State Board of Medical Examiners
2 Peachtree Street, 6th Floor
Atlanta, GA 30303-3465
Phone: (404) 656-3913
Fax: (404) 656-9723
Web Site: http://www.sos.state.ga.us/ebd-medical/

Georgia Board of Dentistry
237 Coliseum Drive
Macon, GA 31217-3858
Phone: (478) 207-1680
Fax: (478) 207-1685
Web Site: http://www.sos.state.ga.us/ebd-dentistry/

HAWAII

Hawaii Board of Medical Examiners
P.O. Box 3469
Honolulu, HI 96801
1010 Richards St., Honolulu, HI 96813
Phone: (808) 586-2708
Fax: (808) 586-2689
Licensing: (808) 586-3000
Fax: (808) 586-3031

Hawaii Board of Dental Examiners
P.O. Box 3469
Honolulu, HI 96801
Phone: (808) 586-2702
Fax: (808) 586-2704
Licensing: (808) 586-3000
Fax: (586) 586-3031

IDAHO

Idaho State Board of Medicine
P.O. Box 83720
Boise, ID 83720-0058
Westgate Office Plaza, 1755 Westgate Drive, Suite 140
Phone: (208) 327-7000
Fax: (208) 327-7005

Idaho State Board of Dentistry
P.O. Box 83720
Boise, ID 83720-0021
Phone: (208) 334-2369
Fax: (208) 334-3247
Web Site: http://www2.state.id.us/isbd

ILLINOIS

Illinois Department of Professional Regulation
320 W. Washington Street
Springfield, IL 62786
Phone: (217) 785-0800
Fax: (217) 782-7645
Web Site: http://www.dpr.state.il.us/WHO/med.cfm

Illinois Board of Dentistry
Department of Professional Regulation
320 W. Washington Street
Springfield, IL 62786
Phone: (217) 785-0800
Web Site: http://www.dpr.state.il.us/WHO/dent.cfm

INDIANA

Indiana Health Professions Bureau
402 W. Washington Street, Room W041
Indianapolis, IN 46204
Phone: (317) 232-2960
Fax: (317) 233-4236
Web Site: http://www.ai.org/hpb

Indiana State Board of Dentistry
402 W. Washington Street, Room W041
Indianapolis, IN 46204
Phone: (317) 233-4406
Web Site: http://www.accessindiana.com/hpb/isbde/

IOWA

Iowa Board of Medical Examiners
400 S.W. 8th Street, Suite C
Des Moines, IA 50309-4686
Phone: (515) 281-5171
Fax: (515) 242-5908
Web Site: http://www.docboard.org/ia/ia_home.htm
E-mail: ibme@bon.state.ia.us

Iowa Board of Dental Examiners
400 S.W. 8th Street, Suite D
Des Moines, IA 50309
Phone: (515) 281-5157
Fax: (515) 281-7969
Web Site: http://www.state.ia.us/dentalboard/

KANSAS

Kansas State Board of Healing Arts
235 S. Topeka Boulevard
Topeka, KS 66603-3068
Phone: (785) 296-7413
Fax: (785) 296-0852
Web Site: http://www.ksbha.org/
E-mail: Healer3@ink.org

Kansas Dental Board
3601 S.W. 29th Street, Suite 134
Topeka, KS 66614-2062
Phone: (785) 273-0780
Fax: (785) 273-7545
E-mail: dental@ink.org

KENTUCKY

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
Phone: (502) 429-8046
Fax: (502) 429-9923
Web Site: http://www.state.ky.us/agencies/kbml

Kentucky Board of Dentistry
10101 Linn Station Road
Louisville, KY 40223
Phone: (502) 423-0573
Fax: (502) 423-1239

LOUISIANA

Louisiana State Board of Medical Examiners
P.O. Box 30250
New Orleans, LA 70190-0250
630 Camp Street, New Orleans, LA 70130
Phone: (504) 524-6763
Fax: (504) 599-0503
Web Site: http://www.lsbme.org/
E-mail: Lsbmever@lsbme.org

Louisiana State Board of Dentistry
365 Canal Street, Suite 2680
New Orleans, LA 70130
Phone: (504) 568-8574
Fax: (504) 568-8598
Web Site: http://www.lsbd.org

MAINE

Maine Board of Licensure in Medicine
137 State House Station
Augusta, ME 04333-0137
Phone: (207) 287-3601
Fax: (207) 287-6590
Web Site: http://www.docboard.org/me/me_home.htm

Maine Board of Osteopathic Licensure
142 State House Station
2 Bangor Street
Augusta, ME 04333-0142
Phone: (207) 287-2480
Fax: (207) 287-3015
Web Site: http://www.docboard.org/me-osteo/

Maine Board of Dental Examiners
143 State House Station
2 Bangor Street
Augusta, ME 04333-0143
Phone: (207) 287-3333
Fax: (207) 287-8140
Web Site: http://www.state.me.us/pfr/auxboards/denhome.htm

MARYLAND

Maryland Board of Physician Quality Assurance
4201 Patterson Avenue
Baltimore, MD 21215-0095
Phone: (410) 764-4777
Toll Free: 1-800-492-6836
Fax: (410) 358-2252
Web Site: http://www.docboard.org/md/default.htm
E-mail: BPQA@erols.com

Maryland Board of Dental Examiners
Spring Grove Hospital Center
Benjamin Rush Building
55 Wade Avenue
Baltimore, MD 21228
Phone: (410) 402-8500
Fax: (410) 358-0128

MASSACHUSETTS

Massachusetts Board of Registration in Medicine
10 West Street
Boston, MA 02111
Phone: (617) 727-3086
Fax: (617) 451-9568
Web Site: http://www.massmedboard.org
E-mail: webmaster@massmedboard.org

Massachusetts Board of Registration in Dentistry
239 Causeway Street, Suite 500
Boston, MA 02114
Phone: (617) 727-9928
Web Site: http://www.state.ma.us/reg/boards/dn

MICHIGAN

Michigan Board of Medicine
P.O. Box 30670
Lansing, MI 48909-7518
611 W Ottawa Street, 1st Floor, Lansing, MI 48933
Phone: (517) 373-6873
Fax: (517) 373-2179
Web Site: http://www.cis.state.mi.us/bhser/

Michigan Board of Osteopathic Medicine and Surgery
P.O. Box 30670
Lansing, MI 48909-7518
611 W Ottawa Street, 1st Floor, Lansing, MI 48933
Phone: (517) 373-6873
Fax: (517) 373-2179
Web Site: http://www.cis.state.mi.us/bhser/

Michigan Board of Dentistry
P.O. Box 30670-7518
Lansing, MI 48909
611 W Ottawa Street, 1st Floor, Lansing, MI 48933
Phone: (517) 373-9102
Fax: (517) 373-2179

MINNESOTA

Minnesota Board of Medical Practice
2829 University Avenue S.E., Suite 400
Minneapolis, MN 55414-3246
Phone: (612) 617-2130
Fax: (612) 617-2166
Web Site: http://www.bmp.state.mn.us

Minnesota Board of Dentistry
2829 University Avenue, S.E., Suite 450
Minneapolis, MN 55414-3249
Phone: (612) 617-2250
Fax: (612) 617-2260
Web Site: http://www.dentalboard.state.mn.us

MISSISSIPPI

Mississippi State Board of Medical Licensure
1867 Crane Ridge Drive, Suite 200-B
Jackson, MS 39216
Phone: (601) 987-3079
Fax: (601) 987-4159
Web Site: http://www.msbml.state.ms.us

Mississippi State Board of Dental Examiners
600 East Amite Street, Suite 100
Jackson, MS 39201-2801
Phone: (601) 944-9622
Fax: (601) 944-9624
Web Site: http://www.msbde.state.ms.us/

MISSOURI

Missouri State Board of Registration for the Healing Arts
3605 Missouri Blvd.
P.O. Box 4
Jefferson City, MO 65102
Phone: (573) 751-0098
Fax: (573) 751-3166
Web Site: http://www.ecodev.state.mo.us/pr/healarts
E-mail: healarts@mail.state.mo.us

Missouri State Dental Board
3605 Missouri Blvd.
P.O. Box 1367
Jefferson City, MO 65102
Phone: (573) 751-0040
Fax: (573) 751-8216
Web Site: http://www.ecodev.state.mo.us/pr/dental/
E-mail: dental@mail.state.mo.us

MONTANA

Montana Board of Medical Examiners
301 South Park, 4th Floor
P.O. Box 200513
Helena, MT 59620-0513
Phone: (406) 841-2360
Fax: (406) 841-2363
Web Site: http://www.com.state.mt.us/License/POL/pol_boards/med_board/board_page.htm
E-mail: compolmed@state.mt.us

Montana Board of Dentistry
301 South Park, 4th Floor
P.O. Box 200513
Helena, MT 59620-0513
Phone: (406) 841-2390
Fax: (406) 841-2305
Web Site: http://www.com.state.mt.us/License/POL/pol_boards/den_board/board_page.htm
E-mail: compolden@state.mt.us

NEBRASKA

Nebraska State Board of Examiners
in Medicine and Surgery
P.O. Box 94986
Lincoln, NE 68509-4986
301 Centennial Mall South
Phone: (402) 471-2118
Fax: (402) 417-3577
Web Site: http://www.hhs.state.ne.us/crl/crlindex.htm

Nebraska Board of Examiners in Dentistry
P.O. Box 94986
Lincoln, NE 68509-4986
Phone: (402) 471-2118

NEVADA

Nevada Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510
1105 Terminal Way, Suite 301, Reno, Nevada 89502
Phone: (775) 688-2559
Fax: (775) 688-2321
Toll Free: (888) 890-8210
Web Site: http://www.state.nv.us/medical/
E-mail: nsbme@govmail.state.nv.us

Nevada State Board of Osteopathic Medicine
2950 E. Flamingo Road, Suite E-3
Las Vegas, NV 89121-5208
Phone: (702) 732-2147
Fax: (702) 732-2079

Nevada State Board of Dental Examiners
2295-B Renaissance Dr.
Las Vegas, NV 89119
Phone: (702) 486-7044
Toll Free: 1-800-DDS-EXAM
Fax: (702) 486-7046
Web Site: http://www.nvdentalboard.org
E-mail: nsbde@govmail.state.nv.us

NEW HAMPSHIRE

State of New Hampshire Board of Medicine
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520
Phone: (603) 271-1203
Fax: (603) 271-6702
Web Site: http://www.state.nh.us/medicine

New Hampshire Board of Dental Examiners
2 Industrial Park Drive
Concord, NH 03301-8520
Phone: (603) 271-4561
Fax: (603) 271-6702
Web Site: http://webster.state.nh.us/dental/

NEW JERSEY

New Jersey State Board of Medical Examiners
P.O. Box 183
Trenton, NJ 08625-0183
140 E. Front Street, 2nd Floor
Phone: (609) 826-7100
Fax: (609) 984-5930
Web Site: http://www.state.nj.us/lps/ca/medical.htm

New Jersey State Board of Dentistry
124 Halsey Street
P.O. Box 45005
Newark, NJ 07101
Phone: (973) 504-6405
Fax: (973) 273-8075
Web Site: http://www.state.nj.us/lps/ca/medical.htm

NEW MEXICO

New Mexico State Board of Medical Examiners
491 Old Santa Fe Trail
Lamy Building, 2nd Floor
Santa Fe, NM 87501
Phone: (505) 827-5022
Toll Free: 1-800-945-5845
Fax: (505) 827-7377
Web Site: http://www.nmbme.org

New Mexico Board of Osteopathic Examiners Board
2055 Pacheco Street, Suite 400
P.O. Box 25101
Santa Fe, NM 87505
Phone: (505) 476-7120
Fax: (505) 827-7095
Web Site: http://www.rld.state.nm.us/b&c/osteopathic_examiners_board.htm
E-mail: OsteoBoard@state.nm.us

New Mexico Board of Dental Health Care
2055 Pacheco Street, Suite 400
Santa Fe, NM 87504
Phone: (505) 476-7125
Web Site:
http://www.rld.state.nm.us/b&c/dentalIndex.htm
E-mail: DentalBoard@state.nm.us

NEW YORK

Office of Professional Medical Conduct
New York State Department of Health
433 River Street, Suite 303
Troy, NY 12180
Phone: (518) 402-0855
Fax: (518) 402-0866
Web Site: http://www.health.state.ny.us
E-mail: opmc@health.state.ny.us

New York State Board for Medicine
Cultural Education Center, Room 3023
Empire State Plaza
Albany, NY 12230
Phone: (518) 474-3841
Fax: (518) 486-4846
Web Site: http://www.op.nysed.gov
E-mail: medbd@mail.nysed.gov

New York State Board for Dentistry
Cultural Education Center
Room 3055
Albany, NY 12230
Phone: (518) 474-3858
Fax: (518) 473-6995
Web Site: http://www.op.nysed.gov
E-mail: dentbd@mail.nysed.gov

NORTH CAROLINA

North Carolina Medical Board
P.O. Box 20007
Raleigh, NC 27619
1201 Front Street, Suite 100, Raleigh, NC 27609
Phone: (919) 326-1100
Fax: (919) 326-1130
Web Site: http://www.docboard.org/nc/
E-mail: info@ncmedboard.org

North Carolina State Board of Dental Examiners
P.O. Box 32270
Raleigh, NC 27622-2270
3716 National Drive, Raleigh, NC 27612
Phone: (919) 781-4901
Fax: (919) 571-4197
Web Site: http://www.ncdentalboard.org/
E-mail: info@ncdentalboard.org

NORTH DAKOTA

North Dakota State Board of Medical Examiners
City Center Plaza
418 E. Broadway, Suite 12
Bismarck, ND 58501
Phone: (701) 328-6500
Fax: (701) 328-6505
Web Site: http://www.ndbomex.com/

North Dakota State Board of Dental Examiners
P.O. Box 7246
Bismarck, ND 58507-7246
Phone: (701) 258-8600
Fax: (701) 224-9824
Web Site: http://www.nddentalboard.org/
E-mail: ndbde@aptsd.com

OHIO

State of Ohio Medical Board
77 S. High Street, 17th Floor
Columbus, OH 43266-0315
Phone: (614) 466-3934
Complaint Line: 1-800-554-7717
Fax: (614) 728-5946
Web Site: http://www.state.oh.us/med/

Ohio State Dental Board
77 S. High Street, 18th Floor
Columbus, OH 43266-0306
Phone: (614) 466-2580
Fax: (614) 752-8995
Web Site: http://webtest.state.oh.us/dpn/

OKLAHOMA

Oklahoma Board of Medical Licensure and Supervision
P.O. Box 18256
Oklahoma City, OK 73154-0256
5104 N. Francis Street, Suite C, Oklahoma City, OK 73118
Phone: (405) 848-6841
Fax: (405) 848-8240
Web Site: http://www.osbmls.state.ok.us/
E-mail: supportservices@osbmls.state.ok.us

Oklahoma Board of Osteopathic Examiners
4848 N. Lincoln Boulevard, Suite 100
Oklahoma City, OK 73105-3321
Phone: (405) 528-8625
Fax: (405) 557-0653
Web Site: http://www.docboard.org/ok/ok.htm

Oklahoma Board of Dentistry
6501 N. Broadway, Suite 220
Oklahoma City, OK 73116
Phone: (405) 848-1564
Fax: (405) 848-5279
Web Site: http://www.state.ok.us/~dentist/
E-mail: dentist@oklaosf.state.ok.us

OREGON

Oregon Board of Medical Examiners
620 Crown Plaza
1500 S.W. First Avenue
Portland OR, 97201-5826
Phone: (503) 229-5770
Fax: (503) 229-6543
Web Site: http://www.bme.state.or.us/
E-mail: bme.info@state.or.us

Oregon Board of Dentistry
1515 S.W. 5th Avenue, Suite 602
Portland, OR 97201-5451
Phone: (503) 229-5520
Fax: (503) 229-6606
Web Site: http://www.oregondentistry.org/
E-mail: information@oregondentistry.org

PENNSYLVANIA

Pennsylvania State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
Phone: (717) 787-1400
Fax: (717) 787-7769
Web Site: http://www.dos.state.pa.us/bpoa/medbd/mainpage.htm
E-mail: medicine@pados.dos.state.pa.us

Pennsylvania State Board of Osteopathic Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
Phone: (717) 783-4858
Fax: (717) 787-7769
Web Site: http://www.dos.state.pa.us/bpoa/ostbd/mainpage.htm
E-mail: osteopat@pados.dos.state.pa.us

Pennsylvania State Board of Dentistry
P.O. Box 2649
Harrisburg, PA 17105-2649
Phone: (717) 783-7162
Fax: (717) 787-7769
Web Site: http://www.dos.state.pa.us/bpoa/denbd/mainpage.htm
E-mail: dentistr@pados.dos.state.pa.us

RHODE ISLAND

Rhode Island Board of Medical Licensure and Discipline
Department of Health
3 Capitol Hill, Room 205
Providence, RI 02908-5097
Phone: (401) 222-5855
Fax: (401) 222-2158
Web Site: http://www.docboard.org/ri/main.htm

Rhode Island Board of Examiners in Dentistry
3 Capitol Hill, Room 404
Providence, RI 02908-5097
Phone: (401) 222-2151

SOUTH CAROLINA

South Carolina Board of Medical Examiners
P.O. Box 11289
Columbia, SC 29211-1289
Koger Office Park, Kingstree Building
110 Centerview Drive, Suite 202, Columbia, SC 29210
Phone: (803) 896-4500
Fax: (803) 896-4515
Web Site: http://www.llr.state.sc.us/me.htm
E-mail: medboard@mail.llr.state.sc.us

South Carolina Board of Dentistry
P.O. Box 11329
Columbia, SC 29211-1329
Koger Office Park, Kingstree Building
110 Centerview Drive, Columbia, SC 29210
Phone: (803) 896-4599
Fax: (803) 896-4596
Web Site: http://www.llr.state.sc.us/denlic.htm

SOUTH DAKOTA

South Dakota Board of Medical and Osteopathic Examiners
1323 S. Minnesota Avenue
Sioux Falls, SD 57105
Phone: (605) 334-8343
Fax: (605) 336-0270
Web Site: http://www.state.sd.us/dcr/medical/med-hom.htm

South Dakota State Board of Dentistry
P.O. Box 1037
Pierre, SD 57501
Phone: (605) 224-1282
Fax: (605) 224-7426
Web Site: http://www.state.sd.us/dcr/dentistry/dent-hom.htm
E-mail: sdsbd@dtgnet.com

TENNESSEE

Tennessee Board of Medical Examiners
1st Floor, Cordell Hull Building
425 5th Avenue North
Nashville, TN 37247-1010
Phone: (615) 532-4384
Fax: (615) 532-5369
Web Site: http://170.142.76.180/bmf-bin/BMFproflist.pl

Tennessee Board of Osteopathic Examiners
1st Floor, Cordell Hull Building
425 5th Avenue North
Nashville, TN 37247-1010
Phone: (615) 532-4384
Fax: (615) 532-5369
Web Site: http://170.142.76.180/bmf-bin/BMFproflist.pl

Tennessee Board of Dentistry
1st Floor, Cordell Hull Building
425 5th Avenue North
Nashville, TN 37247-1010
Phone: (615) 532-3202
Fax: (615) 532-5369
Web Site: http://170.142.76.180/bmf-bin/BMFproflist.pl

TEXAS

Texas State Board of Medical Examiners
P.O. Box 2018
Austin, TX 78768-2018
333 Guadalupe, Tower 3, Suite 630, Austin, TX 78701
Phone: (512) 305-7010
Fax: (512) 305-7008
Complaint Line: 1-800-201-9353
Web Site: http://www.tsbme.state.tx.us/

Texas State Board of Dental Examiners
333 Guadalupe, Tower 3, Suite 800
Austin, TX 78701
Phone: (512) 463-6400
Fax: (512) 463-7452
Web Site: http://www.tsbde.state.tx.us/

UTAH

Utah Physicians Licensing Board
Division of Occupational and Professional Licensing
P.O. Box 146741
Salt Lake City, UT 84114-6741
160 East 300 South, 4th Floor, Salt Lake City, UT 84102
Phone: (801) 530-6628
Fax: (801) 530-6511
Web Site: http://www.commerce.state.ut.us/dopl/dopl1.htm
E-mail: bdopl.pfairbur@email.state.ut.us

Utah Board of Dentists and Dental Hygienists
Division of Occupational and Professional Licensing
P.O. Box 146741
Salt Lake City, UT 84114-6741
160 East 300 South, Salt Lake City, UT 84102
Phone: (801) 530-6740
Fax: (801) 530-6511
Web Site: http://www.commerce.state.ut.us/dopl/dopl1.htm
E-mail: brdopl.pfairhur@email.state.ut.us

VERMONT

Vermont Board of Medical Practice
109 State Street
Montpelier, VT 05609-1106
Phone: (802) 828-2673
Fax: (802) 828-5450
Web Site:
http://www.docboard.org/vt/vermont.htm

Vermont Board of Osteopathic Physicians and Surgeons
Office of Professional Regulation
26 Terrace Street, Drawer 09
Montpelier, VT 05609-1101
Phone: (802) 828-2375
Fax: (802) 828-2465
Web Site: http://www.vtprofessionals.org/oprbegin.htm

Vermont Board of Dental Examiners
26 Terrace Street, Drawer 09
Montpelier, VT 05609-1106
Phone: (802) 828-2390
Fax: (802) 828-2465
Web Site: http://vtprofessionals.org/dentists/

VIRGINIA

Virginia Board of Medicine
6606 W. Broad Street, 4th Floor
Richmond, VA 23230-1717
Phone: (804) 662-9908
Fax: (804) 662-9943
Web Site: http://www.dhp.state.va.us/levelone/med.htm
E-mail: medbd@dhp.state.va.us

Virginia Board of Dentistry
6606 W. Broad Street, 4th Floor
Richmond, VA 23230-1717
Phone: (804) 662-9906
Web Site: http://www.dhp.state.va.us/levelone/den.htm
E-mail: denbd@dhp.state.va.us

WASHINGTON

Washington State Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
1300 Quince Street S.E., Olympia, WA 98501
Phone: (360) 236-4800
Fax: (360) 586-4573
Web Site: http://www.doh.wa.gov/medical/default.htm

Washington Board of Osteopathic Medicine and Surgery
P.O. Box 47870
Olympia, WA 98504-7870
1300 Quince Street S.E., Olympia, WA 98501
Phone: (360) 236-4945
Fax: (360) 586-0745
Web Site: http://www.doh.wa.gov/hsqa/hpqad/Osteopath/default.htm

Dental Quality Assurance Commission
P.O. Box 47867
Olympia, WA 98504-7867
1300 Quince Street S.E., Olympia, WA 98501
Phone: (360) 236-4865
Fax: (360) 664-9077
Web Site: http://www.doh.wa.gov/hsqa/hpqad/Dental/default.htm

WEST VIRGINIA

West Virginia Board of Medicine
101 Dee Drive
Charleston, WV 25311
Phone: (304) 558-2921
Fax: (304) 558-2084
Web Site: http://www.wvdhhr.org/wvbom/

West Virginia Board of Osteopathy
334 Pence Road
Welrton, WV 26062
Phone: (304) 723-4638
Fax: (304) 723-2877
E-mail: bdosteo@mail.wvnet.edu

West Virginia Board of Dental Examiners
P.O. Drawer 1459
Beckley, WV 25802-1459
Phone: (304) 252-8266
Fax: (304) 252-2779
E-mail: apsa@citynet.net

WISCONSIN

Wisconsin Medical Examining Board
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935
1400 E. Washington Avenue, Room 142, Madison, WI 53703
Phone: (608) 266-2112
Fax: (608) 267-0644
Web Site: http://badger.state.wi.us/agencies/drl/Regulation/html/dod279.html
E-mail: dorl@drl.state.wi.us

Wisconsin Dentistry Examining Board
Bureau of Health Professions
Department of Regulation & Licensing
P.O. Box 8935
Madison, WI 53708
1400 E. Washington Avenue
Phone: (608) 266-2811
Web Site: http://www.drl.state.wi.us/agencies/drl/Regulation/html/dod087.html

WYOMING

Wyoming Board of Medicine
211 West 19th Street
Colony Building, 2nd Floor
Cheyenne, WY 82002
Phone: (307) 778-7053
Fax: (307) 778-2069

Wyoming Board of Dental Examiners
P.O. Box 272
Kemmerer, WY 83101
Phone: (307) 777-6529

U.S. TERRITORIES

The following U.S Territories are defined as States in §60.3 of the Data Bank Regulations.

AMERICAN SAMOA

Department of Medical Services
American Samoa Government
LBJ Tropical Medical Center
Turner Drive
Pago Pago, AS 96799
Phone: 011 (684) 633-4590
Fax: 011 (684) 633-1869
Web Site: http://www.samoanet.com/asg/

GUAM

Guam Board of Medical Examiners
Health Professional Licensing Office
P.O. Box 2816
Hagatna, GU 96932
Phone: 011 (671) 475-0251
Fax: 011 (671) 477-4733
Web Site: http://www.visitguam.org/GVB/Govindex.html

NORTHERN MARIANAS

CNMI Board of Professional Licensing
P.O. Box 2078
Saipan, MP 96950
Phone: (670) 234-5897
Fax: (670) 234-6040
Web Site: http://www.marianas-islands.gov.mp/contact.htm

PUERTO RICO

Puerto Rico Board of Medical Examiners
P.O. Box 13069
San Juan, PR 00908
Kennedy Avenue, ILA Bldg., Hogar del Obrero, Portuario, Piso 5, Puerto Nuevo 00920
Phone: (787) 782-8989
Fax: (787) 782-8733

Puerto Rico Board of Dental Examiners
P.O. Box 10200
San Juan, PR 00908
Phone: (787) 725-8161

VIRGIN ISLANDS

Virgin Islands Board of Medical Examiners
Department of Health
48 Sugar Estate
St. Thomas, VI 00802
Phone: (340) 774-0117
Fax: (340) 777-4001

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APPENDIX A: Glossary

This glossary contains terms that relate to the National Practitioner Data Bank (NPDB), and the definitions apply only to their usage in conjunction with the NPDB and its policies and procedures.

adverse action — (1) an action taken against a practitioner's clinical privileges or medical staff membership in a health care entity, or (2) a licensure disciplinary action.

Adverse Action Codes — a list of adverse actions and the codes used to identify them when submitting reports to the NPDB.

Adverse Action Report (AAR)— the format used by health care entities and State Licensing Boards to report an adverse action taken against a physician, dentist, or other health care practitioner.

adversely affects — reduces, restricts, suspends, revokes, or denies clinical privileges or membership in a health care entity.

authorized agent — an individual or organization that an eligible entity designates to query the NPDB on its behalf. In most cases, an authorized agent is an independent contractor to the requesting entity (for instance, a county medical society or state hospital association) used for centralized credentialing. An authorized agent cannot query the NPDB without designation from an eligible entity.

authorized submitter — an individual empowered by an eligible entity to submit reports or queries to the NPDB. The authorized submitter certifies the legitimacy of information in a query or report submitted to the NPDB. In most cases, the authorized submitter is an employee of the eligible entity (such as an Administrator or Medical Staff Director).

board of medical examiners — a body or subdivision of such body that is designated by a State for licensing, monitoring, and disciplining physicians or dentists. This term includes boards of allopathic or osteopathic examiners, a composite board, a subdivision, or an equivalent body as determined by the State.

clinical privileges — privileges, membership on the medical staff, and other circumstances (including panel memberships) in which a physician, dentist, or other licensed health care practitioner is permitted to furnish medical care by a health care entity.

Correction — a change intended to supersede a report in the NPDB.

Data Bank Identification Number (DBID) — a unique, 15-digit, identification number assigned to eligible entities and authorized agents when they register with the NPDB. Entities and agents need this number to query and report to the NPDB using the IQRS. The DBID must be included on all correspondence to the NPDB.

dentist — a doctor of dental surgery, a doctor of dental medicine, or the equivalent who is legally authorized to practice dentistry by a State, or who, without authority, holds himself or herself out to be so authorized.

Department of Health and Human Services (HHS)— the Government agency responsible for administration of the NPDB.

dispute — a formal, written objection of the accuracy of a report or the fact that a specific event was reported to the NPDB. Disputes may be made only by the subject of a report.

Data Bank Control Number (DCN) — the identification number assigned by the NPDB that is used to identify each query and report. Eligible entities use the DCN when submitting a Correction or a Void to the NPDB.

draft—a report that is temporarily stored without being submitted to the NPDB-HIPDB for processing. Reporters may create drafts of any type of report and store them for future retrieval for up to 30 days. Draft reports are not required to have all mandatory data elements completed and are not considered valid submissions to the NPDB-HIPDB.

Drug Enforcement Administration (DEA) — the Government agency that registers practitioners to dispense controlled substances and assigns practitioners Federal DEA Numbers.

Electronic Funds Transfer (EFT) — a method of electronic payment for NPDB queries. Entities may authorize their banks to directly debit their accounts in order to pay for queries processed by the NPDB. To use the Electronic Funds Transfer payment method, entities must provide to the NPDB the account number, routing code, and type of account (checking or savings) for the bank account from which fee payment is authorized.

eligible entity — an entity that is entitled to query and/or report to the NPDB under the provisions of Title IV of Public Law 99-660, as specified in 45 CFR Part 60. Eligible entities must certify their eligibility to the NPDB in order to query and/or report.

Entity Primary Function Codes — two-digit code that best describes the primary function your entity performs. The code is used on the *Entity Registration* form.

formal peer review process — the conduct of professional review activities through formally adopted written procedures that provide for adequate notice and an opportunity for a hearing.

Freedom of Information Act (FOIA) — the law that provides public access to Federal Governmental records. See the Information Sources chapter of this *Guidebook*.

***Health Care Quality Improvement Act of 1986*, as amended** — Title IV of Public Law 99-660; legislation intended to improve the quality of medical care by encouraging hospitals, State Licensing Boards, and other health care entities, including professional societies, to

identify and discipline those who engage in unprofessional behavior; and to restrict the ability of incompetent practitioners to move from State to State without disclosure or discovery of the practitioners' previous damaging or incompetent performance.

health care entity — (1) a hospital; (2) an entity that provides health care services and follows a formal peer review process for the purpose of furthering quality health care; or (3) a professional society or a committee or agent thereof, including those at the national, State, or local level, of physicians, dentists, or other health care practitioners, that follows a formal peer review process for the purpose of furthering quality health care.

health care practitioner — an individual other than a physician or dentist (1) who is licensed or otherwise authorized by a State to provide health care services, or (2) who, without State authority, holds himself or herself out to be authorized to provide health care services.

hospital [as described in Section 1861(e)(1) and (7) of the *Social Security Act*] — an institution primarily engaged in providing, by or under the supervision of physicians, to inpatients (1) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or (2) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and, if required by State or local law, is licensed or is approved by the agency of the State or locality responsible for licensing hospitals as meeting the standards established for such licensing.

ICD Transfer Program (ITP) — a program that transmits Interface Control Document (ICD) report and query files to and from the NPDB-HIPDB. This option is used by entities that do not have access to the IQRS, or prefer to generate reports and queries using custom software.

Initial Report — the original record of a medical malpractice payment or adverse action submitted by a reporting entity. An eligible entity references an Initial Report (using the DCN) when submitting a Correction, Void, or Revision to Action.

Integrated Querying and Reporting Service (IQRS) — an electronic, Internet-based system for querying and reporting to the NPDB and the HIPDB.

Interface Control Document (ICD) — a file format for the NPDB-HIPDB that represents all components of reports and queries. Entities who do not have access to the Internet may ftp their queries and reports in ICD format.

licensure disciplinary action — (1) revocation, suspension, restriction, or acceptance of surrender of a license; and (2) censure, reprimand, or probation of a licensed physician or dentist based on professional competence or professional conduct.

medical malpractice payer — an entity that makes a medical malpractice payment through an insurance policy or otherwise for the benefit of a practitioner.

medical malpractice payment — a monetary exchange as a result of a settlement or judgment of a written complaint or claim demanding payment based on a physician's, dentist's, or other licensed health care practitioner's provision of or failure to provide health care services, and may include, but is not limited to, the filing of a cause of action, based on the law of tort, brought in any State or Federal Court or other adjudicative body.

Medical Malpractice Payment Report — the format used by medical malpractice payers to report a medical malpractice payment made for the benefit of a physician, dentist, or other health care practitioner.

NPDB-HIPDB Customer Service Center — The Customer Service Center encompasses all the tools and services that the Data Banks use to support customers. Questions may be directed to Information Specialists at the Customer Service Center by e-mail at *npdb-hipdb@sra.com* or by phone at 1-800-767-6732 (TDD 1-703-802-9395).

Occupation/Field of Licensure Codes — a list of occupational activities/licensure categories for health care practitioners, providers, and suppliers, and the codes used to identify them.

physician — a doctor of medicine or osteopathy who is legally authorized to practice medicine or surgery by a State, or who, without authority, holds himself or herself out to be so authorized.

Portable Document Format (PDF) — files with a .pdf extension, such as Adobe Acrobat Reader files. Format used for NPDB query and report responses and other forms accessed via the IQRS.

practitioner — a physician, dentist, or other licensed health care practitioner.

Privacy Act — the law that establishes safeguards for the protection of Federal systems of records the Government collects and keeps on individual persons. See the Information Sources chapter of this *Guidebook*.

professional review action — an action or recommendation of a health care entity:

(1) taken in the course of professional review activity;

(2) based on the professional competence or professional conduct of an individual physician, dentist, or other health care practitioner which affects or could affect adversely the health or welfare of a patient or patients; and

(3) which adversely affects or may adversely affect the clinical privileges of the physician, dentist, or other health care practitioner.

(4) This term excludes actions which are primarily based on: (a) the physician's, dentist's, or other health care practitioner's association, or lack of association, with a professional

society or association; (b) the physician's, dentist's, or other health care practitioner's fees or the physician's, dentist's, or other health care practitioner's advertising or engaging in other competitive acts intended to solicit or retain business; (c) the physician's, dentist's, or other health care practitioner's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis; (d) a physician's, dentist's, or other health care practitioner's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional; or (e) any other matter that does not relate to the professional competence or professional conduct of a physician, dentist, or other health care practitioner.

professional review activity — an activity of a health care entity with respect to an individual physician, dentist, or other health care practitioner: (1) to determine whether the physician, dentist, or other health care practitioner may have clinical privileges with respect to, or membership in, the entity; (2) to determine the scope or conditions of such privileges or membership; or (3) to change or modify such privileges or membership.

professional society — an association of physicians or dentists that follows a formal peer review process for the purpose of furthering quality health care.

QPRAC — software previously available from the NPDB that allowed eligible entities to query and report electronically either via network telecommunication using a modem or on diskettes submitted by mail. QPRAC has been replaced by the IQRS.

query — a request for information submitted to the NPDB by an eligible entity or authorized agent via the IQRS or ICD format.

report — record of a medical malpractice payment or adverse action submitted to the NPDB by an eligible entity. Reports may be submitted via the IQRS or by ITP using the appropriate ICD format.

Revision to Action — an action relating to and modifying an adverse action previously reported to the NPDB. A Revision to Action does not supersede a previously reported adverse action. An entity that reports an Initial adverse action must also report any revision to that action.

Secretary — the Secretary of Health and Human Services.

Secretarial Review — the recourse provided a practitioner in the event that he or she disputes a report to the NPDB and the reporting entity (1) declines to change the report or (2) does not respond. The Secretary of HHS will review the case and determine whether the report is factually accurate or should have been reported to the NPDB.

self-query — a subject's request for information contained in the NPDB-HIPDB about himself or herself. All self-query requests are automatically submitted to both the NPDB and the HIPDB. A self-query may not be sent to only one Data Bank.

State — the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

State licensing board — a generic term used to refer to State medical and dental boards, as well as those bodies responsible for licensing other heath care practitioners.

State medical or dental board — a board of medical examiners.

subject statement — a statement of up to 2,000 characters (including spaces and punctuation) or less submitted by a subject practitioner regarding a report contained in the NPDB.

Void — a retraction of a report in its entirety. Voided reports are not disclosed in response to queries, including self-queries by practitioners. Reports may be voided only by the reporting entity or the Secretary of HHS through Secretarial Review.

45 Code of Federal Regulations Part 60 (45 CFR 60) — Federal regulations that govern the NPDB. See Appendix B.

APPENDIX B: Laws and Regulations

The following laws and regulations apply to the National Practitioner Data Bank. The full text can be accessed by clicking the web site link next to each.

Title IV of Public Law 99-660, complete text of the *Health Care Quality Improvement Act of 1986*, as amended. *http://www.npdb-hipdb.com/info/legislation/title4.html*

Title IV Regulations, complete text of the 45 CFR Part 60, October 17, 1989. *http://www.npdb-hipdb.com/info/legislation/45cfr60.html*

Civil Money Penalties, 42 CFR Part 1003. *http://www.npdb-hipdb.com/info/legislation/42cfr.html*

Freedom of Information Act (FOIA). The provisions of FOIA, 5 USC §552, affect the dissemination of information contained in the NPDB. *http://www.npdb-hipdb.com/info/legislation/foia.html*

Privacy Act of 1974; Alteration of System of Records - The *Privacy Act* affects the dissemination of information contained in the NPDB. Please reference the *Privacy Act*, 5 USC §552a. *http://www.npdb-hipdb.com/info/legislation/privacy.html*

Final rule in the *Federal Register* on March 1, 1999, that removes the prohibition against the NPDB charging for self-queries, and therefore, allows the NPDB to assess costs in an equitable manner. *http://www.npdb-hipdb.com/pubs/fedreg3-1-99.pdf*

Notice in the *Federal Register* on March 1, 1999, announcing a $10 fee for health care practitioners who request information about themselves (self-query) from the NPDB, effective March 31, 1999. *http://www.npdb-hipdb.com/pubs/fedreg3-1-99.pdf*

APPENDIX C: Abbreviations

AAR	Adverse Action Report
BHPr	Bureau of Health Professions
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration)
DBID	Data Bank Identification Number
DCN	Data Bank Control Number
DEA	Drug Enforcement Administration
DQA	Division of Quality Assurance
EFT	Electronic Funds Transfer
FOIA	Freedom of Information Act
HHS	U.S. Department of Health and Human Services
HIPDB	Healthcare Integrity and Protection Data Bank
HMO	Health Maintenance Organization
HRSA	Health Resources and Services Administration
ICD	Interface Control Document
ITP	(ICD) Transfer Protocol
IQRS	Integrated Querying and Reporting Service
LAE	Loss Adjustment Expense
MCO	Managed Care Organization
MMER	Medicare/Medicaid Exclusion Report
MMPR	Medical Malpractice Payment Report
NPDB	National Practitioner Data Bank
OIG	Office of Inspector General/HHS
PDF	Portable Document File
PPO	Preferred Provider Organization
QPRAC	Query on Practitioners
RVD	Report Verification Document
SND	Subject Notification Document
SSN	Social Security Number
TDD	Telecommunications Device for the Deaf
TIN	Taxpayer Identification Number